

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

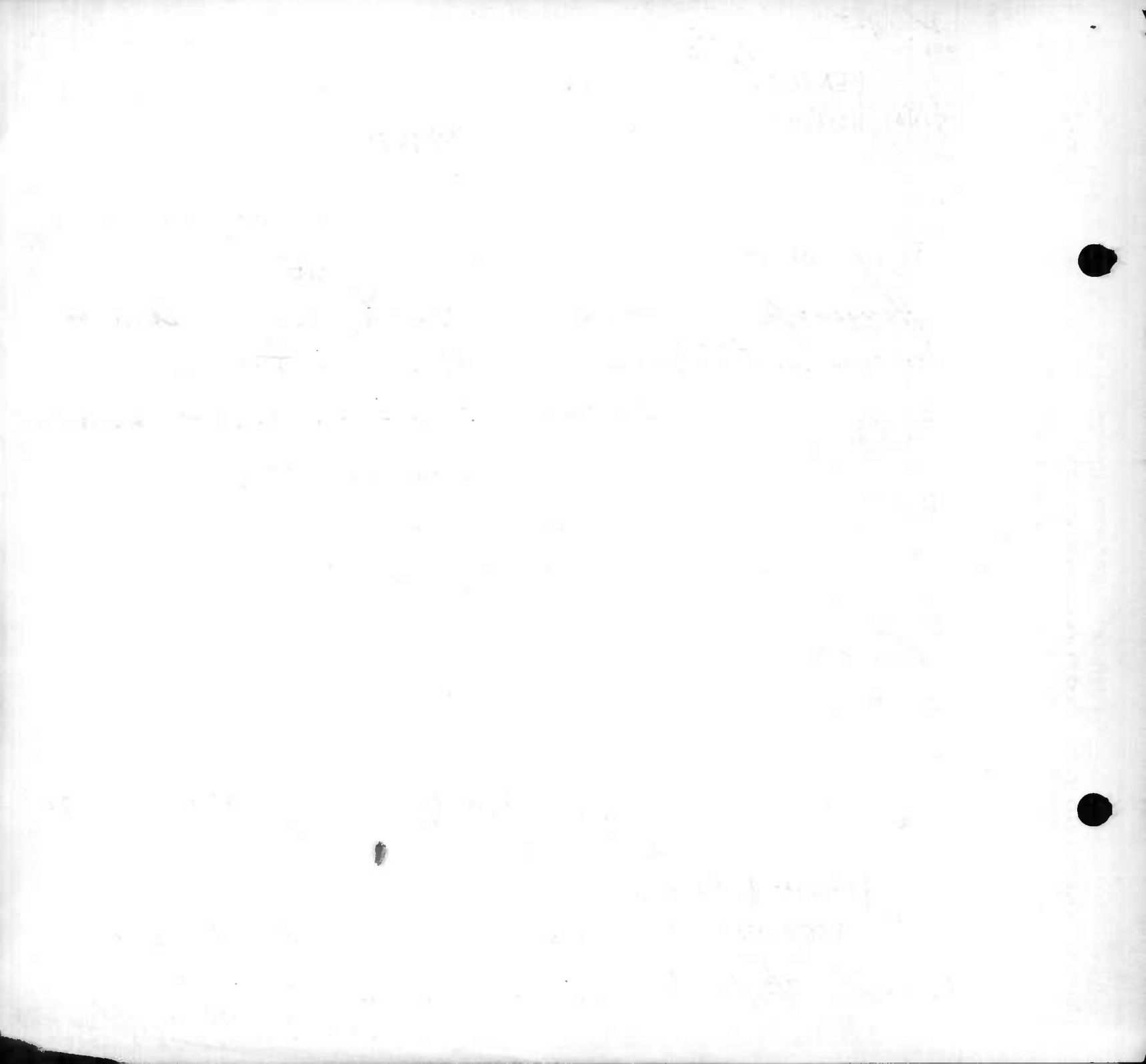
A-430		70 7501		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7501	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
2. DATE AND HOUR OF DEATH				George Alt			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY			
C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
E. STREET AND NUMBER				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX				6. RACE			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH			
9. AGE (In years lost birthday)				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT				ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) INTERMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				19. DATE OF OPERATION			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ to _____ that (I) (we) last saw the deceased alive on _____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				23A. SIGNATURE			
23B. DATE SIGNED				23C. PHYSICIAN'S NAME (Type)			
23D. ADDRESS				24A. BURIAL CREMATION, REMOVAL (Specify)			
24B. DATE				24C. NAME OF CEMETERY OR CREMATORY			
24D. LOCATION (City, town, or county) (State)				25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR			
25D. ADDRESS				25E. ADDRESS			



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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7502	
BIRTH NO. <u>K-645</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>BEATRICE KURLAND</u>		2. DATE AND HOUR OF DEATH <u>7/25/70</u> <u>4:30</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>SINAI HOSPITAL OF BALTO.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MARYLAND</u>	
		B. COUNTY <u>BALTO.</u>		C. CITY OR TOWN <u>BALTO.</u>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>5918 P Cross County Blvd. 21215</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/14/13</u>	9. AGE (In years last birthday) <u>56</u>	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto, Md</u>	
13. FATHER'S NAME <u>Morris Bettelman</u>		14. MOTHER'S MAIDEN NAME <u>Rose Bettelman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-34-5093</u>		17. INFORMANT <u>Frank Kurland</u> ADDRESS <u>Same</u>	
18. <u>250.9 I</u>		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>Pulmonary Edema</u>			
ANTECEDENT CAUSES		(B) <u>HASCD</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>Diabetes Mellitus</u>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>0</u> (this hospital) attended the deceased from <u>7/25/70</u> 19 <u>70</u> to <u>7/25</u> 19 <u>70</u> that <u>we</u> lost saw the deceased alive on <u>7/25/70</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>0</u> (We) (did) <u>did not</u> view the body after death.					
23A. SIGNATURE <u>Fortunato V. Euzaga</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>FORTUNATO V. EUZAGA</u>				23D. ADDRESS <u>SINAI HOSP. OF BALTO.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/26/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Teresa Isabel Church</u>	
24D. LOCATION (City, town, or county) <u>Balto, Md.</u>		24E. (State) <u>Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 29 1970</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Sol. Levinsin</u>		25D. ADDRESS <u>6010 Resist 1194</u>	



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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7508	
P-600 70 7503		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) PEAR, Eva S.		2. DATE AND HOUR OF DEATH 7-23-1970 2:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 2831			
FULL NAME OF HOSPITAL OR INSTITUTION LEVINDALE HOME and Inf. BALTO, MD		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 6604 EBERLE DRIVE, APT. 302			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 69	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME SAMUEL SIMON		14. MOTHER'S MAIDEN NAME FANNIE ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. ETHEL VANGER, 6604 EBERLE DRIVE, APT. 302	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EMBOLUS (B) SMALL BOWEL OBSTRUCTION hours DUE TO, OR AS A CONSEQUENCE OF: A.S.C.V.D years (C) years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 1969 to 7-23 1970 , that (I) (we) last saw the deceased alive on 7-23 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Young Lea Lew M.D.				23B. DATE SIGNED 2-23-70	
23C. PHYSICIAN'S NAME (Type) Young Lea Lew M.D.				23D. ADDRESS LEVINDALE HOME, BALTO, MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-14-70		24C. NAME OF CEMETERY or CREMATORY OHR KNESSETH ISRAEL ANSHE SFARD, BALTIMORE, MARYLAND	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JUL 29 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR SQL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25D. ADDRESS			

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7504	
BIRTH NO. B-251 70 7504				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BERTHA GUTMAN ROSENBUSCH			2. DATE AND HOUR OF DEATH JULY 23, 1970 12 NOON M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOUSE IN THE PINES, BELVEDERE			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2720 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 7008 PARK HEIGHTS AVENUE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-20-1881		9. AGE (In years last birthday) 88
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME EMANUEL GUTMAN		
14. MOTHER'S MAIDEN NAME ROSA ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT MR. LOUIS ROSENBUSCH, JR., 3502 WOODVALLEY DR.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.0 I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction - (B) DUE TO, OR AS A CONSEQUENCE OF: Coronary insufficiency - cerebral & general arteriosclerosis. (C) Hypertensive C.V.D. - Secondary changes APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours few years years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 11, 1970 to July 23, 1970 , that (I) (we) lost saw the deceased alive on July 23, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bernard Cohen, M.D. DEGREE				23B. DATE SIGNED 7/23/70	
23C. PHYSICIAN'S NAME (Type) BERNARD COHEN DEGREE				23D. ADDRESS MARYLANDER APTS.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-24-70		24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW	
24D. LOCATION REISTERSTOWN, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUL 29 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

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BALTIMORE CITY HEALTH DEPARTMENT				70 7505	
G-651				70 7505	
BIRTH NO. <u>Harry Greenblatt</u>				REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Edgewood Nursing Home Harry Greenblatt</u>		2. DATE AND HOUR OF DEATH <u>7-26-70-3⁰⁰ PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Edgewood Nursing Home</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Balto</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Edgewood Nursing Home</u>		C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <u>6414 Park Heights Ave.</u>		APT. <u>C-4</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/7/99</u>	9. AGE (In years last birthday) <u>71</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETAIL</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>MERCHANT</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JONAS GREENBLATT</u>			
14. MOTHER'S MAIDEN NAME <u>ELLA THRONE</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>182-05-2372</u>		17. INFORMANT <u>MRS. RENA GREENBLATT, 6414 PARK HIGHTS. AVE., APT. C-4</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>185X I</u> This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Metastatic prostate carcinoma</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic renal failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~ 6 years</u>	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Chronic renal failure</u>					
19A. DATE OF OPERATION <u>2/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>to prostate</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/1/70</u> to <u>7/26/70</u> and that (I) (we) last saw the deceased alive on <u>7/25</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Norman Zimmerman MD</u>		23B. DATE SIGNED <u>7/26/70</u>		23C. PHYSICIAN'S NAME (Type) <u>NORMAN ZIMMERMAN</u>	
23D. ADDRESS <u>100 W MONUMENT ST.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
24B. DATE <u>7-27-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>CHIZUK AMUNO</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 29 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taber, R.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	

~~Handwritten text at top right, possibly crossed out.~~

Handwritten notes on the left side, including "17" and "P.P.P.P."

Handwritten notes on the right side, including "✓" and "Handwritten text".

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Handwritten text in the lower middle section, including "Handwritten text" and "Handwritten text".

Bottom section of handwritten text, including "Handwritten text" and "Handwritten text".

FUNERAL DIRECTOR: IMPORTANT

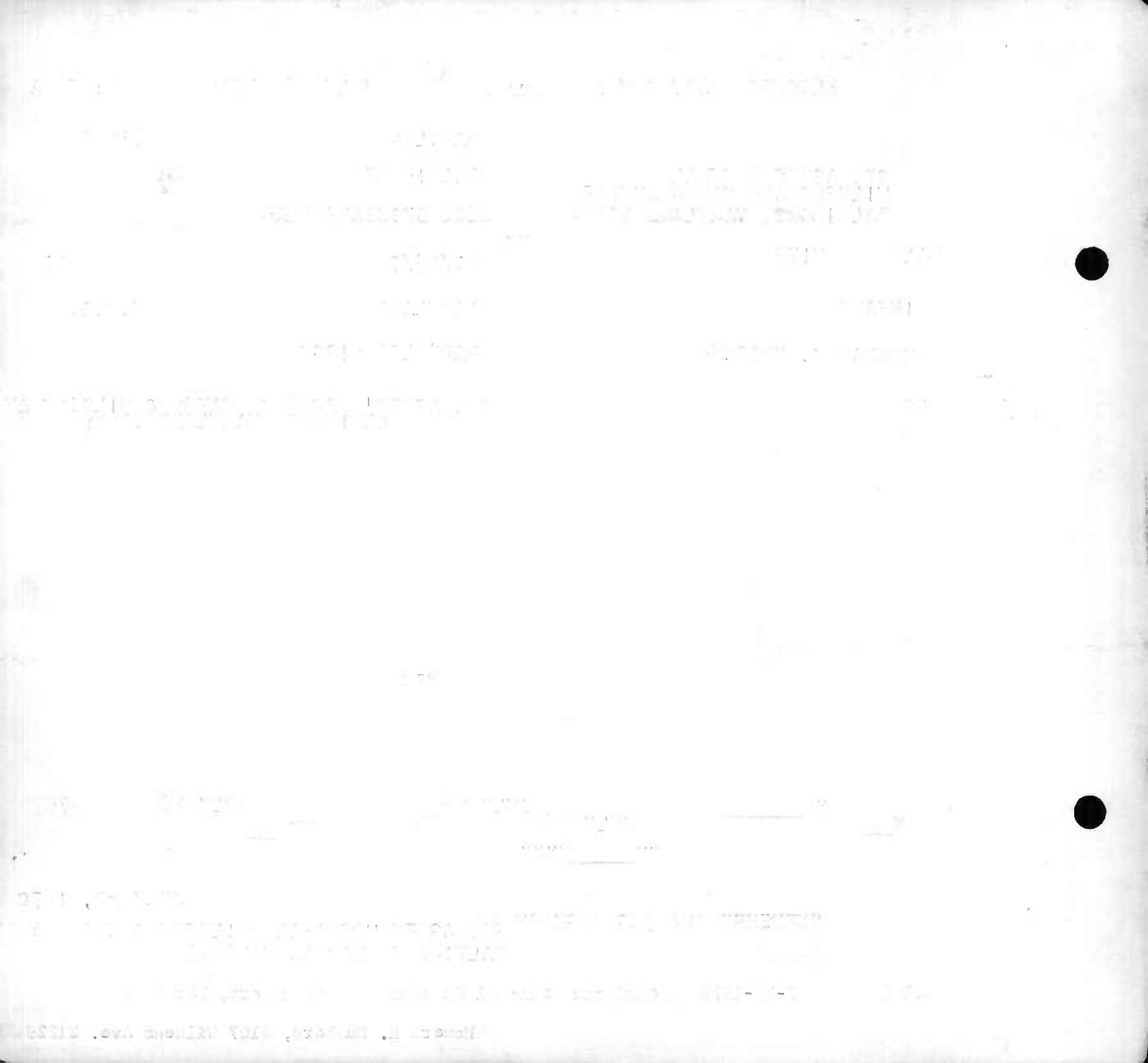
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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7506	
<div style="display: flex; justify-content: space-between;"> X-621 70 7506 </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>					
1. NAME OF DECEASED (Type or Print) Morris Krakovitz			2. DATE AND HOUR OF DEATH JULY 24, 1970 6:30 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 42			A. STATE MARYLAND B. COUNTY BALTIMORE		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 6958 BROOKMILL ROAD, APT. C		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-4-1904	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESSMAN		10B. KIND OF BUSINESS OR INDUSTRY SUN X PAPERS	11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME BENJAMIN			14. MOTHER'S MAIDEN NAME FANNIE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-05-7373	17. INFORMANT MRS. YETTA KRAKOVITZ		
			ADDRESS 6958 BROOKMILL ROAD, APT. C		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardio Respiratory Failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Massive Myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: Atherosclerosis: CUN (C) CUN			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 13 to July 24 1970, that (I) (we) last saw the deceased alive on July 24 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE William D. Bopfelfeld			23B. DATE SIGNED 7/24/70		
23C. PHYSICIAN'S NAME (Type) William D. Bopfelfeld			23D. ADDRESS 6615 Reisterstown Rd		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-26-70		24C. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO	
				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 29 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

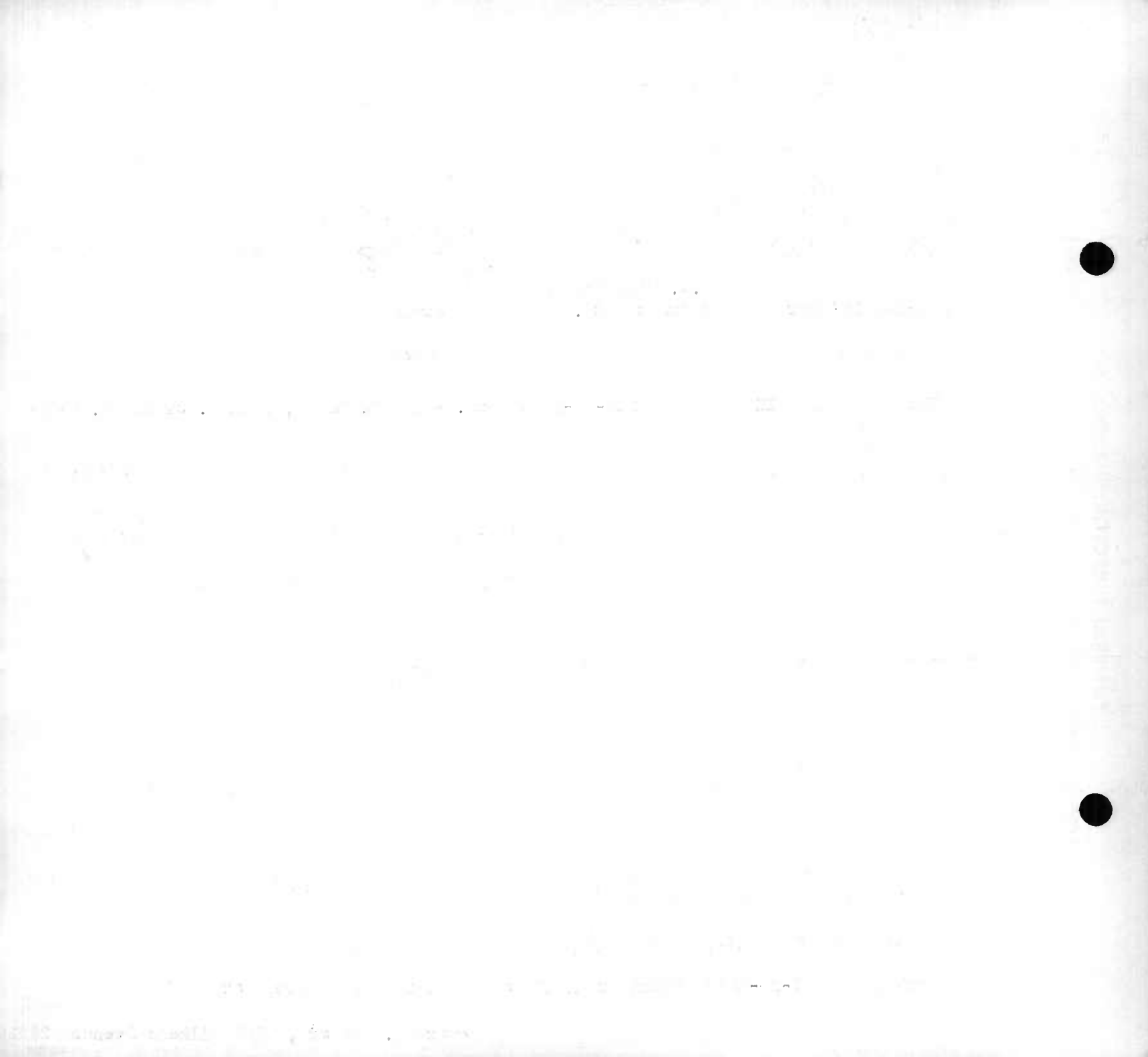
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 7507 4</u>	
BIRTH NO. <u>K-656 70 7507</u> <u>70-12968</u>		1. NAME OF DECEASED (Type or Print) KROENER, BABY BOY JOHN MATTHEW			
2. DATE AND HOUR OF DEATH JULY 26, 1970		1:05 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 21229			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS AND CATON AVENUES BALTIMORE, MARYLAND 21229		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 628 BRISBANE ROAD		2531			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07/26/70	9. AGE (in years last birthday)	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. 23
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME NORMAN J. KROENER			
14. MOTHER'S MAIDEN NAME MARY LEE RIGGS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT ST. AGNES' RECORDS, CATON & WILKENS AV BALTIMORE, MARYLAND 21229			
18. 746.6 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cardio-vascular anomaly.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 26 19 70 to JULY 26 19 70 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JULY 26 19 70 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <i>Chaweng Ongkasuwan M.D.</i>		23B. DATE SIGNED JULY 27, 1970		23C. PHYSICIAN'S NAME (Type) CHAWENG ONGKASUWAN M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-29-1970		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

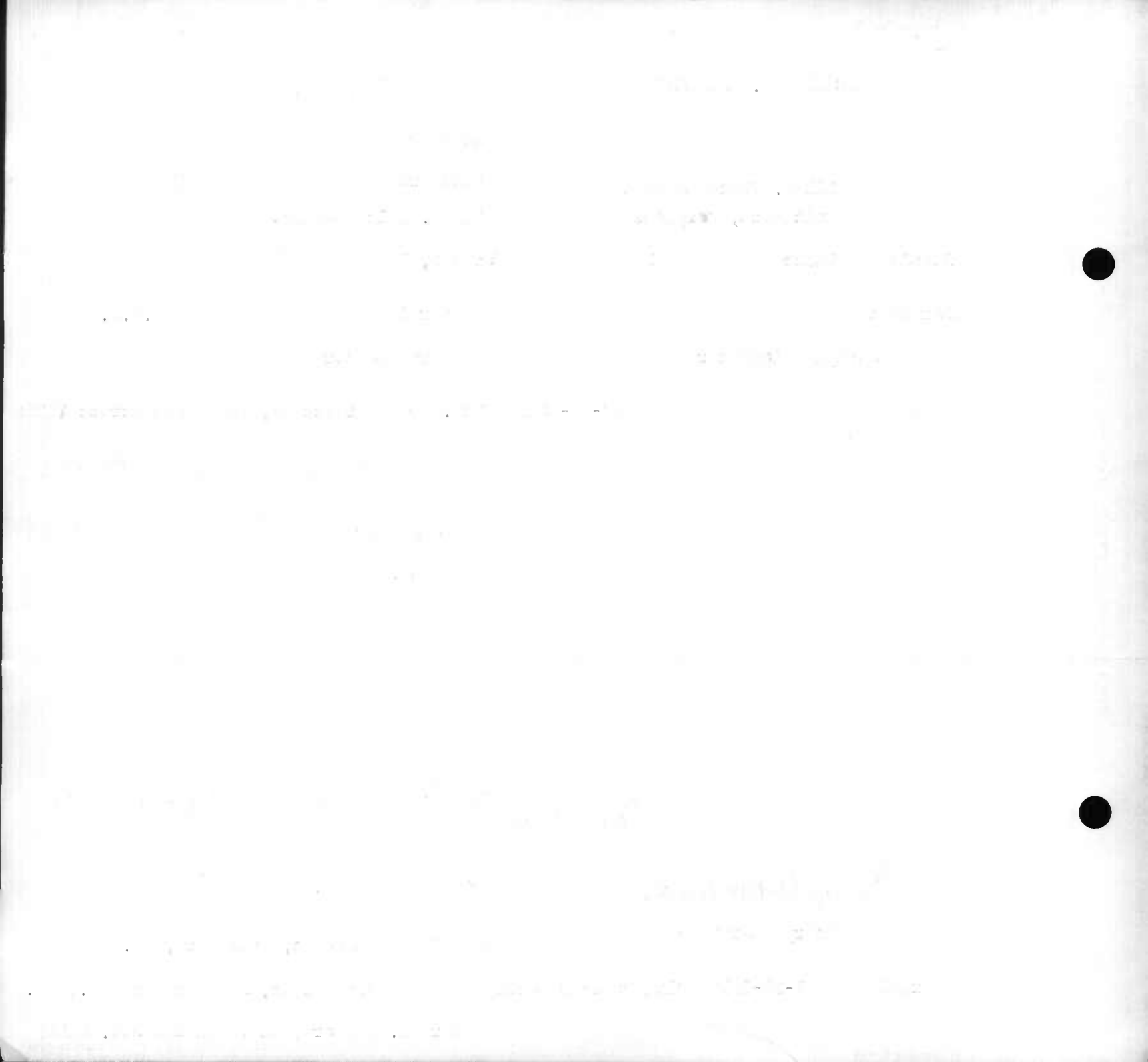
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
G-615 70 7508		70 7508	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Egbert A. GERBEN</u>	
2. DATE AND HOUR OF DEATH <u>7/26/70</u> <u>11:35</u> P.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2102</u>		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Univ. of Md. Hospital</u> <u>22 S. Greene St.</u>	
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1011 W. Cross St</u>		5. SEX <u>m</u> 6. RACE <u>w</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/20/88</u> 9. AGE (In years last birthday) <u>81</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Painter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Fidelity & Guarantee Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>212-18-9839</u>	
17. INFORMANT <u>Mrs. Helen L. Liles, 1011 W. Cross St. 21230</u>		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24hr</u> <u>3days</u> <u>11</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8:29 PM</u> <u>7/26</u> <u>1970</u> to <u>11:35 PM</u> <u>7/26</u> <u>1970</u> and that (I) (we) last saw the deceased alive on <u>11:35</u> <u>7/26</u> <u>1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Joseph B. Sappington, M.D.</u>		23B. DATE SIGNED <u>7/27/1970</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOSEPH B. SAPPINGTON, M.D.</u>		23D. ADDRESS <u>1330 G FINSBURY COURT, LAUREL, MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-30-1970</u>	
24C. NAME of CEMETERY or CREMATORY <u>Baltimore National Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Avenue 21229</u>		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 7509		REG. NO. 70 7509	
BIRTH NO. <div style="font-size: 2em; font-family: cursive;">S-543</div>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) AGNES B. SMALLWOOD				2. DATE AND HOUR OF DEATH July 27, 1970			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 1.5em; font-family: cursive;">00</div> 212 S. Fulton Avenue Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1903 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 212 S. Fulton Avenue			
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 3, 1901	
9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Char Women		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adolph Slaughter				14. MOTHER'S MAIDEN NAME Nora Foster			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-07-4217		17. INFORMANT Mrs. Helen Armstrong, 7926 Main Street 21226			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Acute coronary occlusion Hours DUE TO, OR AS A CONSEQUENCE OF: (B) Myocardial heart disease years DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes mellitus years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month (Day) (Year) (Hour)) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb. 14 1968 to July 27 1970 that (I) (we) last saw the deceased alive on July 27/70 19 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <div style="font-size: 1.5em; font-family: cursive;">Henry Armanas</div>				23B. DATE SIGNED July 28/70		23C. PHYSICIAN'S NAME (Type) Henry Armanas	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7-31-1970		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JUL 29 1970				25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	
24D. LOCATION (City, town, or county) (State) Glen Burnie, Anne Arundel Co., Md.				24E. ADDRESS 1934 Wilkens Avenue, Baltimore, Md.			



FUNERAL DIRECTOR: IMPORTANT

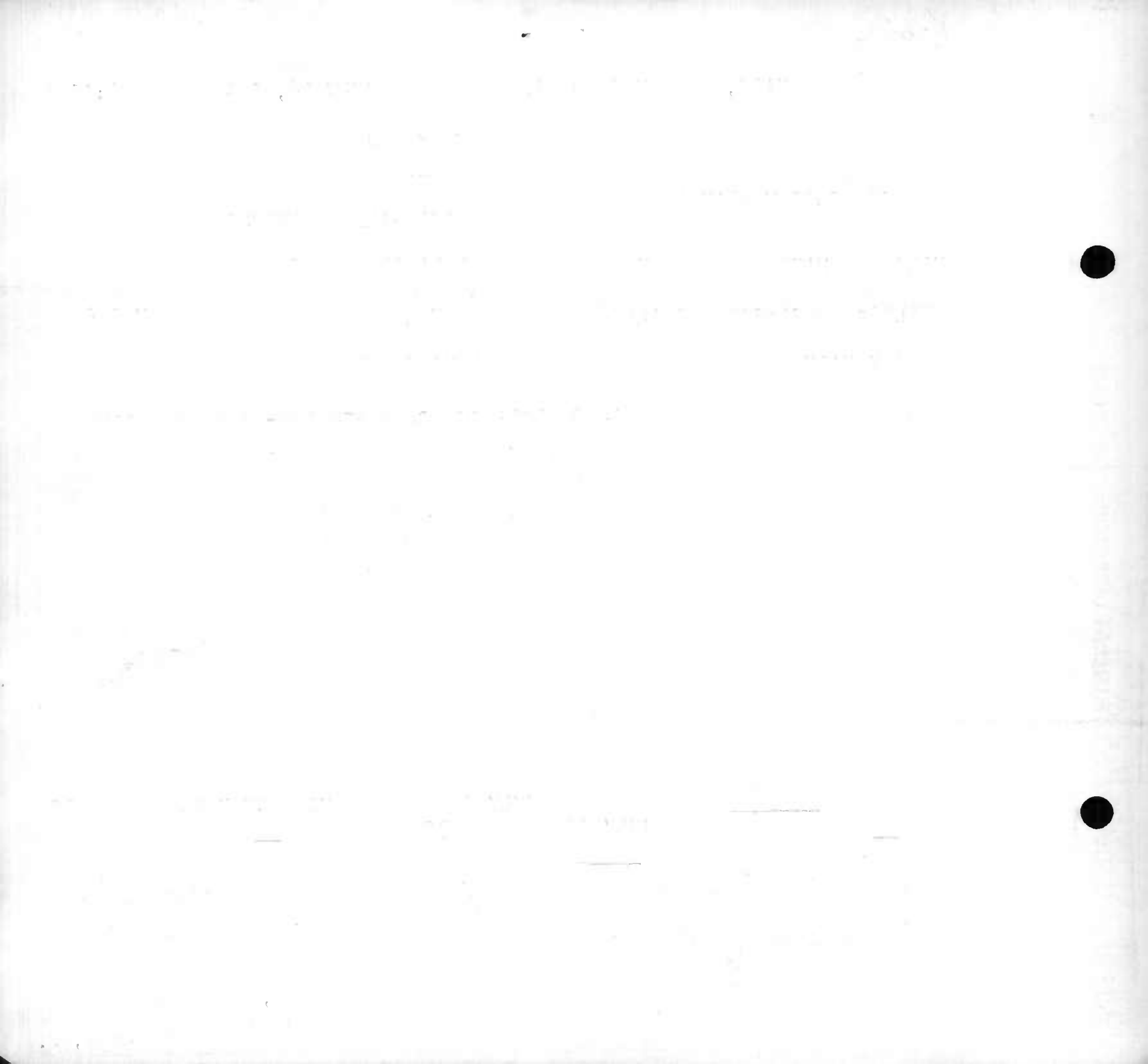
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
W-452		70 7510		70 7510	
1. NAME OF DECEASED (Type or Print) <u>Williams, Gordon B</u>			2. DATE AND HOUR OF DEATH <u>7/27/70</u> <u>945 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>31</u> <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Md. 21224</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2612</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4940 Eastern Ave., Balto., Md. 21224</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-19</u>	9. AGE (In years last birthday) <u>51</u>	If Under 1 Yr. Menstr. Days <u> </u> If Under 24 Hrs. Min. <u> </u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Jacob Williams</u>			14. MOTHER'S MAIDEN NAME <u>Roseann Turner</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>224-18-7910</u>		17. INFORMANT <u>4940 Eastern Avenue</u> ADDRESS BCH Records: <u>Baltimore, Md. 21224</u>	
18. <u>340X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>NO</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>multiple Sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u> </u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>19 yrs</u>
19A. DATE OF OPERATION <u>2 NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u> </u>		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (t) (this hospital) attended the deceased from <u>7-25-61</u> 19 <u> </u> to <u>7/27/70</u> 19 <u> </u> that (t) (we) last saw the deceased alive on <u>7-27</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (t) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ronald Blum</u> M.D. DEGREE			23B. DATE SIGNED <u>7/27/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>Ronald Blum, M.D.</u> DEGREE			23D. ADDRESS <u>Baltimore City Hospital</u> <u>4940 Eastern Ave., Balto., Md. 21224</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7-31-1970</u>	24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 29 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 7511		REG. NO. 70 7511	
BIRTH NO. <u>X-620</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>KIRK, ALBERT FREDERICK</u>				2. DATE AND HOUR OF DEATH <u>JULY 26, 1970</u> <u>4:17 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST AGNES HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2582</u>			
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3154 WILKENS AVENUE</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03 21 12</u>	9. AGE (in years last birthday) <u>58</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD ENGINEER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>ALBERT KIRK</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE OTTEN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216 05 7543</u>		17. INFORMANT ADDRESS <u>433.91 ST AGNES RECORDS-BALTO MD 21229</u>			
18. <u>433.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>NEPHROTIC SYNDROME</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Imaginary heart failure, atherosclerosis</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>with uremia</u> <u>Renal acidosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Occipital brain infarction</u> (C) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Indefinitely medical examined <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>JULY 1</u> 19 <u>70</u> to <u>JULY 26</u> 19 <u>70</u> that (I) <u>(we)</u> lost saw the deceased alive on <u>JULY 26</u> 19 <u>70</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.							
23A. SIGNATURE <u>Albert H. Martin</u>				23B. DATE SIGNED <u>7/26/70</u>		23C. PHYSICIAN'S NAME (Type) <u>ALBERT H. MARTIN</u>	
23D. ADDRESS <u>St Agnes Medical Center</u>				23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/30/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Meadowridge Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Elkridge, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 29 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>R. P. White</u>		25D. ADDRESS <u>Singleton Funeral Home/Glen Burnie, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

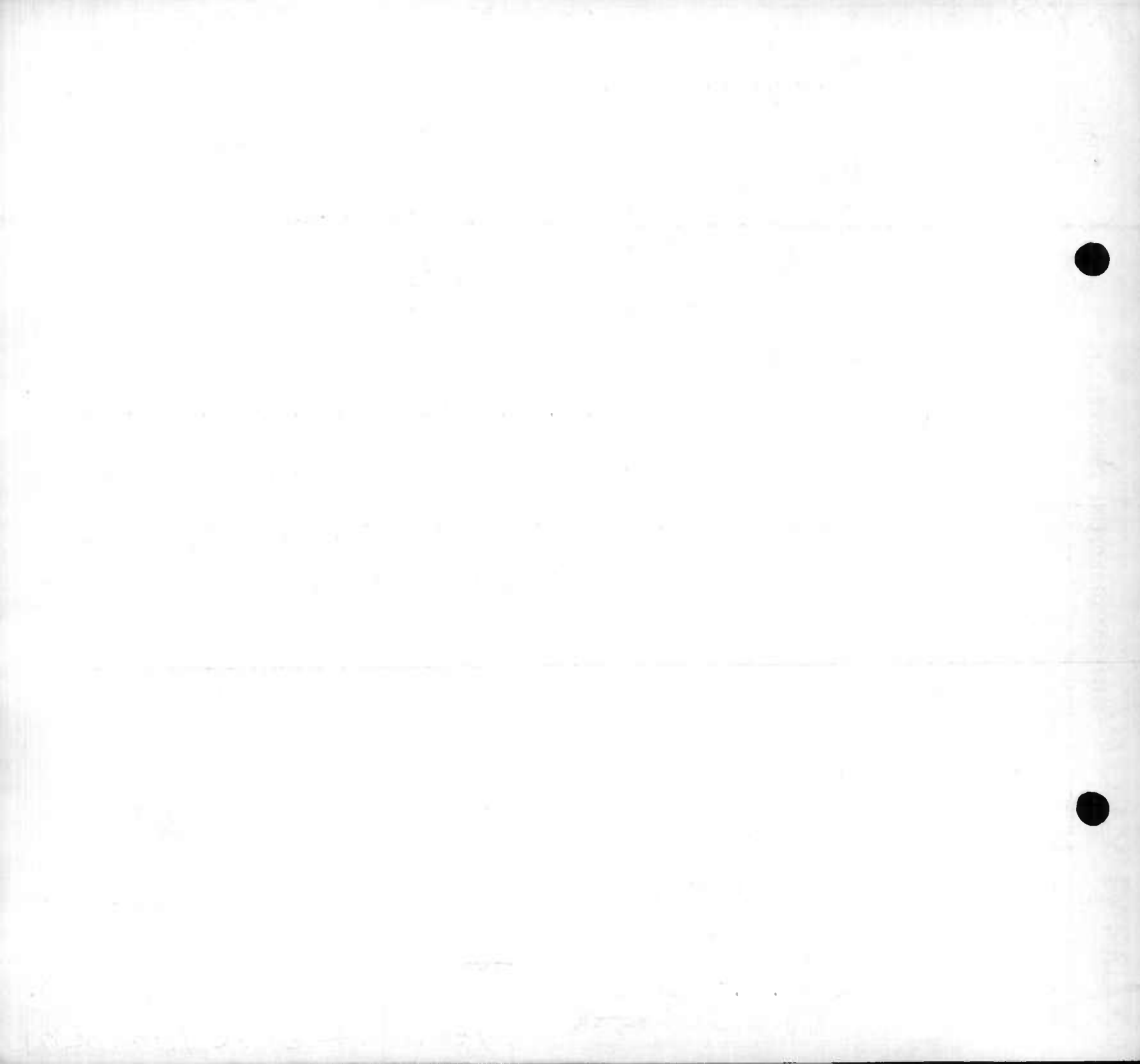
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7512	
BIRTH NO. K-450		70 7512		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MARY C. KELLAM - MRS. JOHN E.			2. DATE AND HOUR OF DEATH 7/27/70 5:20 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY 841		
			C. CITY OR TOWN BALTIMORE		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 3403 ELMLEY AVENUE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-03-94	9. AGE (In years last birthday) 75 7/8 yrs.	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME WILLIAM H. JOHNSON			14. MOTHER'S MAIDEN NAME CARNE THOMAS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 214-12-4627		
17. INFORMANT JOHN E KELLAM - 3403 ELMLEY AV			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 4274 + 250.9			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure		
ANTECEDENT CAUSES			(B) ATRIAL FIBRILLATION		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			DIABETES MELLITUS		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/20 1970 to 7/27 1970. that (I) (we) last saw the deceased alive on 7/27 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			23B. DATE SIGNED 7/27		
23C. PHYSICIAN'S NAME (Type) [Signature]			23D. ADDRESS UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/30/70		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	
24D. LOCATION BALTIMORE MD		24E. NAME OF REGISTRAR Robert E. Taylor, Jr.		24F. FUNERAL DIRECTOR ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. JUL 29 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
70 7513					X CERTIFICATE OF DEATH				
BIRTH NO.					REG. NO. 70 7513				
1. NAME OF DECEASED (Type or Print) <u>Benjamin Edward Welter</u>					2. DATE AND HOUR OF DEATH <u>July 25, 1970 8:10 P.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>HANCOCK</u>				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 University of Maryland Hosp Greene St. Balt. Md</u>					C. CITY OR TOWN <u>HANCOCK</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>3/9/13</u>		9. AGE (In years last birthday) <u>57</u>		II Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FAIRCHILDS HILLER AIR CRAFT</u>					11. BIRTHPLACE (State or foreign country) <u>Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Welter</u>					14. MOTHER'S MAIDEN NAME <u>Ida</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO. <u>220.09.9372</u>		17. INFORMANT ADDRESS <u>MAYME V WELLER, 229 MYERS ST. HANCOCK MD.</u>		
18. <u>530.9 I</u> CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardio Respiratory Arrest</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) <u>Massive bleeding from bronchus</u> DUE TO, OR AS A CONSEQUENCE OF:			<u>20 min</u>	
					(C) <u>Tracheo-esophageal fistula</u>			<u>4 wks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>July 25 1970</u> to <u>July 25 1970</u> that (I) (we) last saw the deceased alive on <u>July 25 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>H. JAE Ihm M.D.</u>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>July 25 '70</u>	
23C. PHYSICIAN'S NAME (Type) <u>H. JAE Ihm, M.D.</u>					23D. ADDRESS <u>22 Greene St. Baltimore, Md.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7.29.70</u>		24C. NAME OF CEMETERY or CREMATORY <u>STONE BRIDGE</u>			24D. LOCATION (City, town, or county) (State) <u>RURAL HANCOCK WASHINGTON MD.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 29 1970</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>			25C. FUNERAL DIRECTOR ADDRESS <u>Harold F. Shore Hancock Md</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7514
BIRTH NO. 1-350		70 7514 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
William K. Litten		7-26-70		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Anderson Nursing Home		A. STATE B. COUNTY Maryland Baltimore		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN D. INSIDE CITY LIMITS?		
		Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER 5024 Belle Avenue		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	3-31-1879	91
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Telephone Co.				Wheeling W. Va.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Sam Litten		Anna Simpson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO		212-05-0579		Marion Cowman-5622 Stonington Ave. #7
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				?
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				
ANTECEDENT CAUSES				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
(B) DUE TO, OR AS A CONSEQUENCE OF:				
(C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
Chronic Brain Syndrome				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
Stanley K. Steinback M.D.				7-27-70
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)	
Burial	7-30-70	Lorraine Cemetery	Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS		
JUL 30 1970	Robert E. Farber, M.D.	Armacost Funeral Chapel-4600 Liberty Hts		

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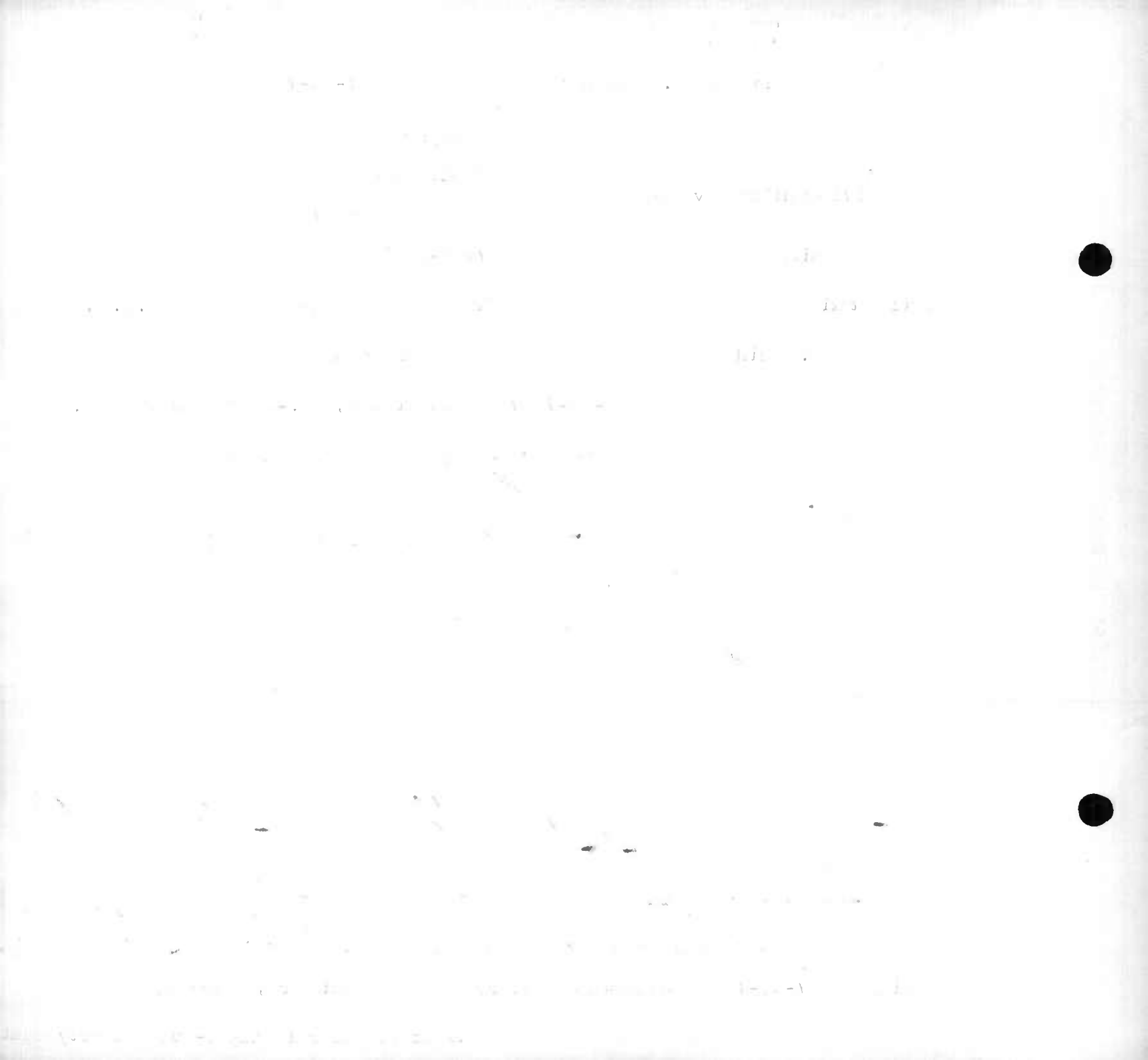
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 70 7515	
BIRTH NO. 17-345		70 7515		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) John C. Maitland			2. DATE AND HOUR OF DEATH 7-26-70 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3738 Milford Avenue			A. STATE Maryland B. COUNTY 2841		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3738 Milford Avenue		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-16-1904	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Brooklyn New York	
13. FATHER'S NAME Howard L. Maitland		14. MOTHER'S MAIDEN NAME Carpenter			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-18-7167		17. INFORMANT ADDRESS John Maitland, Jr. - 324 Westtowne Rd. #29	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last II			CAUSE OF DEATH Acute Myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Atherosclerosis - general > 2 yrs DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes Mellitus		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 3/10 1960 to 7/27 1970 that (I) last saw the deceased alive on 5/7 1970 and that (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.					
23A. SIGNATURE Harvey S. Feuerman			23B. DATE SIGNED 7/27/70		23C. PHYSICIAN'S NAME (Type) Harvey S. Feuerman
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 7-29-70		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970			25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Armacost Funeral Chapel-4600 Liberty Hight



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-155 20 7516				BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 20 7516	
1. NAME OF DECEASED (Type or Print) William Dorsey Coffman				2. DATE AND HOUR OF DEATH July 25, 1970 2:20 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Pr. Georges 6600			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital Wyman Park Drive + 31st Street				C. CITY OR TOWN College Park		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4609 Fox St.							
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Apr. 4, 1944	9. AGE (In years last birthday) 26	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lithographer				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Dorsey Coffman			
14. MOTHER'S MAIDEN NAME Eva Richards				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1963 - ?			
16. SOCIAL SECURITY NO. 213-42-9739				17. INFORMANT ADDRESS Records - USPHS Hospital, Baltimore, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 007.21 + 186X Septicemia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Gastroenteritis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours day months			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Embryonal cell carcinoma							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 8 1970 to July 25 1970 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on July 25 1970 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.							
23A. SIGNATURE Samuel P. Ward, M.D.				23B. DATE SIGNED 7-25-70			
23C. PHYSICIAN'S NAME (Type) Samuel P. Ward, M.D.				23D. ADDRESS US PHS Hospital, Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) July 30 1970		24B. DATE		24C. NAME of CEMETERY or CREMATORY St. Luke		24D. LOCATION (City, town, or county) (State) Manassas Co - Woodstock, Va.	
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Arthur Walters		25D. ADDRESS 754 Carroll St. N.W.	

William Henry Harrison

12 Little North Service Hospital
Wynona East Prince & 2nd Street

M

Little North Service Hospital
Wynona East Prince & 2nd Street

Little North Service Hospital
Wynona East Prince & 2nd Street

Apr. 11, 1944

Washington, D.C.

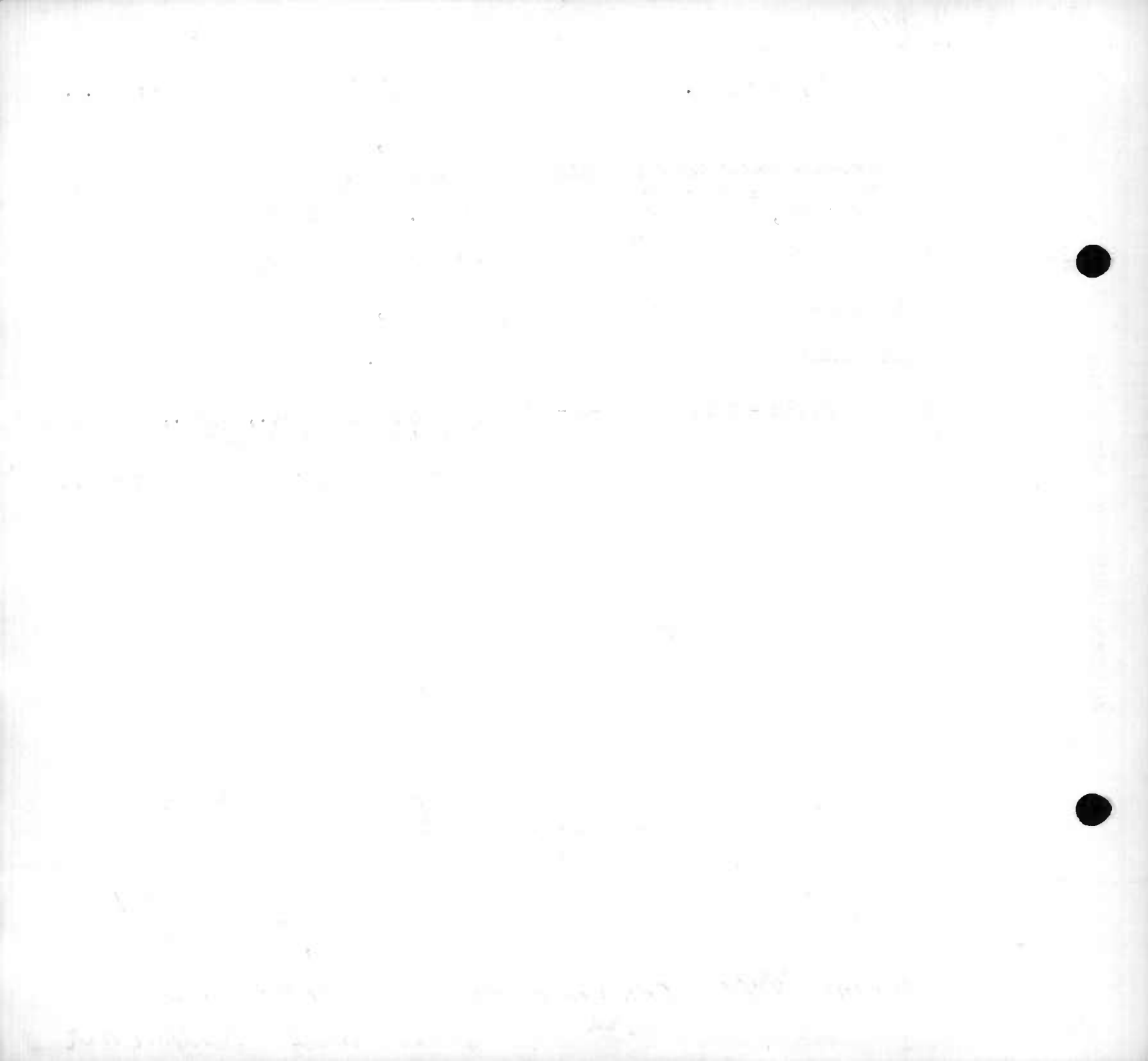
Ever Reuben

Records - USFWS Hospital, Bolton

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

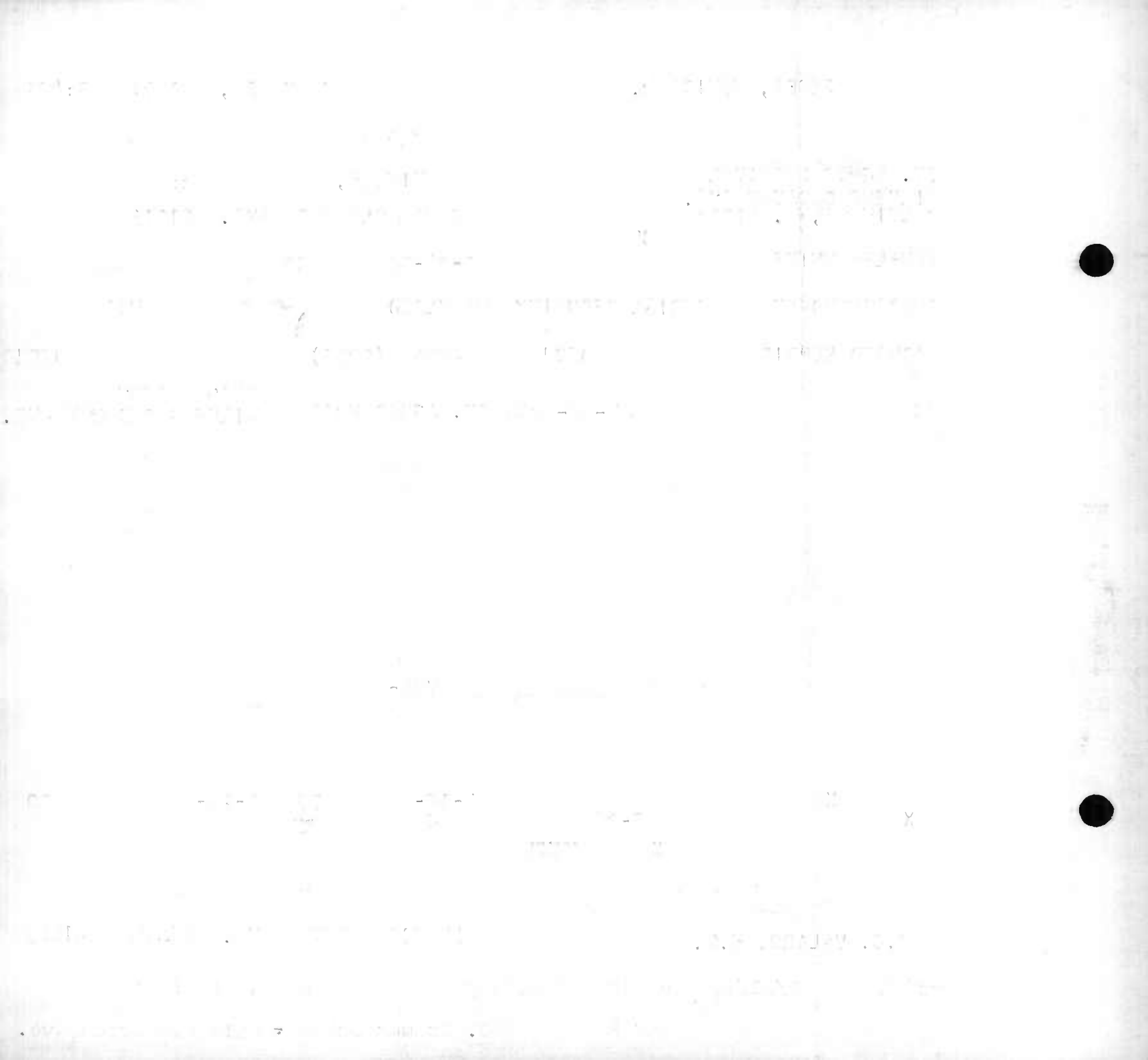
B-360		70 7517		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 7517	
1. NAME OF DECEASED (Type or Print) BADER, Francis X.				2. DATE AND HOUR OF DEATH 7/27/70 4:00 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland, Baltimore B. COUNTY 5300 C. CITY OR TOWN ESSEX D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 322 S. Woodward Drive					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/14/20	9. AGE (in years last birthday) 50	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool planer				10B. KIND OF BUSINESS OR INDUSTRY Martin Co		13. FATHER'S NAME Harry Bader			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5/18/44 - 2/21/46				16. SOCIAL SECURITY NO. 214-18-7008		17. INFORMANT VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218			
18. 1977 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic adenocarcinoma of liver and peritoneum (primary site unidentified) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 7 months (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that XX (this hospital) attended the deceased from July 23rd 19 70 to July 27th 19 70 that XX (we) last saw the deceased alive on July 27th 19 70 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) view the body after death.									
23A. SIGNATURE Myer R. Heyman M.D.				23B. DATE SIGNED 7/27/70		23C. PHYSICIAN'S NAME (Type) Myer R. Heyman			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/30/70		24C. NAME OF CEMETERY OR CREMATORY CAK LAWN CEM.		24D. LOCATION (City, town, or county) (State) BALTO. MD			
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR J. D. Brindley		25D. ADDRESS 3008 face Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

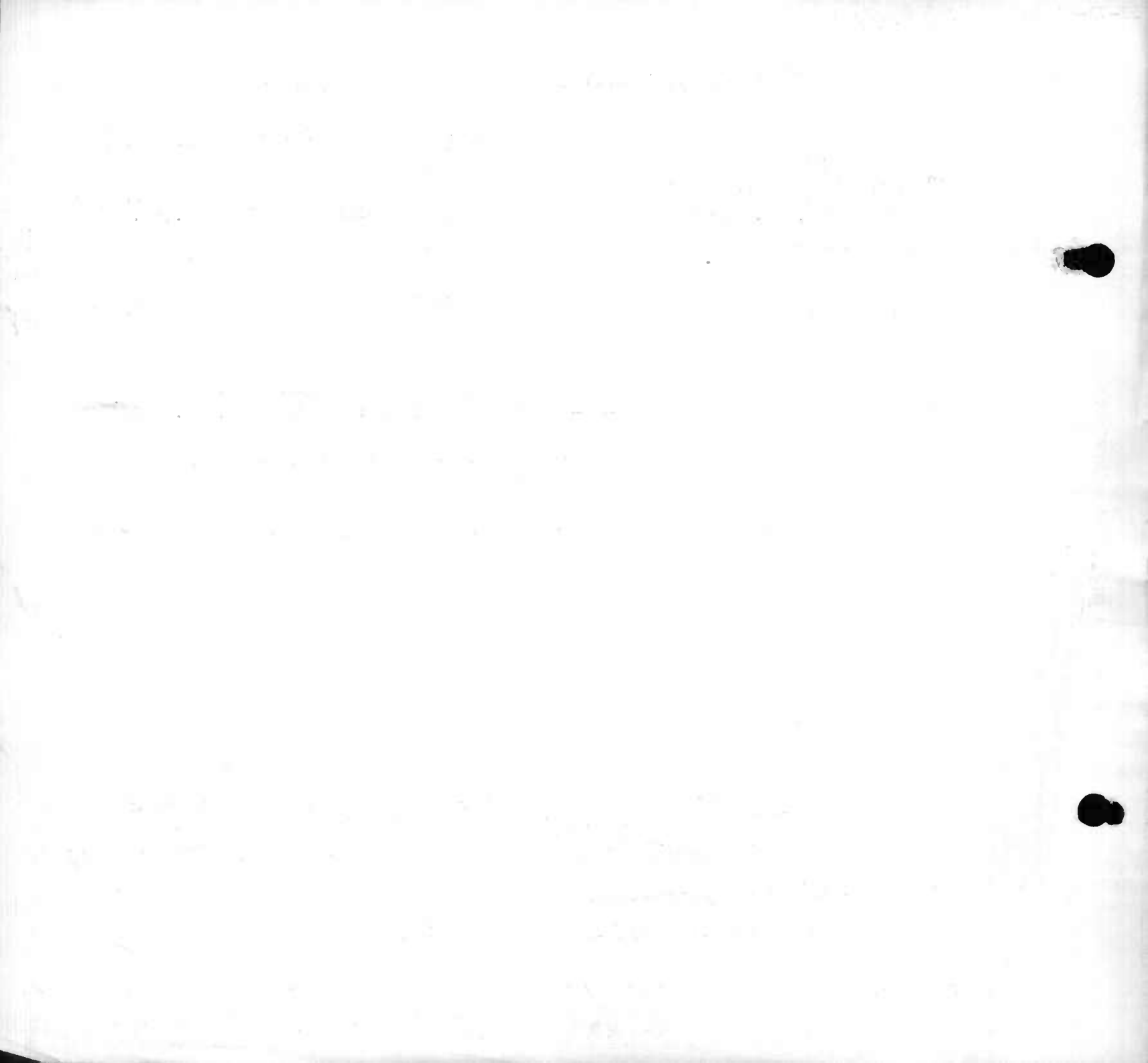
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										REG. NO. <u>70 7518</u>		
BIRTH NO. <u>S-200 70 7518</u>												
1. NAME OF DECEASED (Type or Print) <u>SESSA, MONICA H.</u>					2. DATE AND HOUR OF DEATH <u>JULY 28, 1970 7:45A.</u>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>831</u>							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>ST. AGNES HOSPITAL</u> <u>WILKENS & CATON AVE.</u> <u>BALTIMORE, MD. 21228</u>					C. CITY OR TOWN <u>BALTIMORE</u>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
					E. STREET AND NUMBER <u>3207 CLARENCE AVE.</u>			21213				
5. SEX <u>FEMALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>03-04-20</u>		9. AGE (In years last birthday) <u>50</u>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CORRESPONDENT</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>SOCIAL SECURITY</u>				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>RICHARD HARRIS</u>					DEC 'D		14. MOTHER'S MAIDEN NAME <u>ANNA (ROSE)</u>					DEC 'D
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>220-09-4082</u>		17. INFORMANT <u>ST. AGNES HOSP</u>			ADDRESS <u>RECORD ROOM</u> <u>WILKENS & CATON AVE.</u>			
18. <u>200-21</u> CAUSE OF DEATH												
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Pancytopenia</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Malignant Lymphoma</u> (B) DUE TO, OR AS A CONSEQUENCE OF:										<u>3 months</u>		
<u>Bone marrow involvement</u> (C) DUE TO, OR AS A CONSEQUENCE OF:										<u>3 months</u>		
II												
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).												
19A. DATE OF OPERATION <u>4/1/70</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bone marrow Bx - Pancytopenia</u>				20A. AUTOPSY? (Yes or No) <u>YES -</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?				
22. I certify that (1) (this hospital) attended the deceased from <u>7-15-</u> 19 <u>70</u> to <u>7-28-</u> 19 <u>70</u> that (2) (we) last saw the deceased alive on <u>7-28</u> 19 <u>70</u> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.												
23A. SIGNATURE <u>Perfecto C. Valaro</u>								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7-28-70</u>		
23C. PHYSICIAN'S NAME (Type) <u>P.C. VALARO, M.D.</u>								23D. ADDRESS <u>WILKENS & CATON AVE. BALTO, MD 21229</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/31/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>				24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 30 1970</u>				25B. NAME OF REGISTRAR <u>John E. Taber, M.D.</u>				25C. FUNERAL DIRECTOR ADDRESS <u>G. Truman Schwab 3512 Frederick Ave.</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-460</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 7519</u>	
1. NAME OF DECEASED (Type or Print) <u>Esther V. Miller</u>			2. DATE AND HOUR OF DEATH <u>7/26/70</u> <u>10:50</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>3 Baltimore City Hospital</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Md. 21224</u>			A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>358 Kane St</u> <u>Balto., Md. 21224</u>		
5. SEX <u>female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-7-05</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-24-6046#</u>	17. INFORMANT <u>BCH Records:</u> ADDRESS <u>4940 Eastern Avenue</u> <u>Baltimore, Md. 21224</u>		
18. <u>342X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) <u>Hemorrhage of Decubitus Vessel</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Parkinson's Disease</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 mins</u> <u>13 yrs</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/5</u> <u>1969</u> to <u>7/26</u> <u>1970</u> that (I) (we) last saw the deceased alive on <u>7/26/70</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>AUTOPSY PERFORMED 7-27-70</u>					
23A. SIGNATURE <u>Michael W. Posen</u>			23B. DATE SIGNED <u>7-26-70</u>		23C. PHYSICIAN'S NAME (Type) <u>Michael W. POZEN</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>7-30-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>CREST LAWN</u>
24D. LOCATION <u>U.S. 40 WEST</u>			24E. CITY, TOWN, OR COUNTY (State) <u>Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 30 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>W. Brub. Dudley, Randolph M.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-362 70 7520 BALTIMORE CITY HEALTH DEPARTMENT X REG. NO. 70 7520

BIRTH NO.

1. NAME OF DECEASED (Type or Print) *Mary T. Peterka*

2. DATE AND HOUR OF DEATH *7/28/70 6:00 A. M.*

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE *MD.* **B. COUNTY** *Baltimore*

C. CITY OR TOWN *Dundalk 21222* **D. INSIDE CITY LIMITS?** YES ☐ NO ☐

E. STREET AND NUMBER *203 Cleveland Ave.*

5. SEX *F* **6. RACE** *W* **7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH *1-19-62* **9. AGE** (In years last birthday) *8* **10. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) *CHILD* **11. BIRTHPLACE** (State or foreign country) *Maryland* **12. CITIZEN OF WHAT COUNTRY?** *USA*

13. FATHER'S NAME *JAMES S.* **14. MOTHER'S MAIDEN NAME** *Theresa*

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) *—* **16. SOCIAL SECURITY NO.** *—* **17. INFORMANT** *HOSPITAL RECORDS* **ADDRESS**

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *Aspiration Pneumonia*

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. *Severe Psychomotor Retardation*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION *7-28-70* **19B. CONDITION FOR WHICH OPERATION WAS PERFORMED** *—* **20A. AUTOPSY?** (Yes or No) *—* **20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?** *—*

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ **21B. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) *—* **21C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location) *—*

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) *—* **21E. INJURY OCCURRED** *White At Work* ☐ *Not White At Work* ☐ **21F. HOW DID INJURY OCCUR?** *—*

22. I certify that (I) (this hospital) attended the deceased from *7-27* *1970* **to** *7-28* *1970* **that (I) (we) last saw the deceased alive on** *7-28-70* **and that in (my) (our) opinion death occurred on the date** *7-28-70* **and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.**

23A. SIGNATURE *Carmen Cempron, M.D.* **23B. DATE SIGNED** *7/28/70*

23C. PHYSICIAN'S NAME (Type) *CARMEN CEMPRON, M.D.* **23D. ADDRESS** *SINAI HOSP. Balto MD*

24A. BURIAL CREMATION, REMOVAL (Specify) *BURIAL* **24B. DATE** *7/30/70* **24C. NAME OF CEMETERY or CREMATORY** *OAK LAWN* **24D. LOCATION** (City, town, or county) (State) *BALTO, CO., MD*

25A. DATE REC'D BY HEALTH DEPT. *JUL 30 1970* **25B. NAME OF REGISTRAR** *Robert E. Taylor, R.D.* **25C. FUNERAL DIRECTOR** *W. E. Levine, Presley, Randall, M.D.* **ADDRESS**

VS 150-REV. 1/1/68

BALTIMORE CITY HEALTH DEPARTMENT				70 7521			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 70 7521			
BIRTH NO.							
1. NAME OF DECEASED (Type or Print)		JOHN I. FRANK		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year July 27, 1970 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Johns Hopkins Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year July 27, 1970		Hour 1:25 P. M.	
6. SEX Male		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTIMORE 21222	
9. DATE OF BIRTH MAY 17, 1912		10. AGE (In years last birthday) 58		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN FRANK		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILL WRIGHT		15. MOTHER'S MAIDEN NAME MAUDIE GUTRIDGE		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 216-10-4012		18. INFORMANT IDA C. FRANK (WIFE)		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Industrial premises		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Sparrows Point 53-00			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) App. 3 weeks prior		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Injured leg while working			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mahalikis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED July 28, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-31-70		24C. NAME OF CEMETERY or CREMATORY ROUNDHILL BAPTIST		24D. LOCATION (City, town, or county) (State) COLONIAL BEACH, VA.	
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR W. Frank Bradley, Rockville, Md.		ADDRESS	

Letter from M.E.'s office

8-18-70

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7522	
BIRTH NO. H-456		70 7522		CERTIFICATE OF DEATH	
1. NAME OF DECEASED <small>(Type or Print)</small> Tilda E. Hallameyer			2. DATE AND HOUR OF DEATH 7-28-70 1220 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HARBOR VIEW NCC			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Md. Baltimore C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6303 Elliott St. 21224		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/28/82	9. AGE (In years last birthday) 87	11. BIRTHPLACE (State or foreign country) KY.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker FURNITURE			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME UNK.			14. MOTHER'S MAIDEN NAME UNK		
15. Was Deceased Ever in U. S. Armed Forces? <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> No		16. SOCIAL SECURITY NO. 214-12-1754		17. INFORMANT ADDRESS Tom I. Wood (CLERGYMAN) 7230 SOLLERS PT. Rd 21222	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> 412.41			CAUSE OF DEATH R.S.C.V.D.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: several yrs		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several yrs		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-5-1969 to 7-1970 that (I) (we) last saw the deceased alive on 7-28-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Ellsworth Cook M.D.				23B. DATE SIGNED 7-28-70	
23C. PHYSICIAN'S NAME (Type) E ELLSWORTH COOK M.D.				23D. ADDRESS 2431 MARYLAND AVE. BALTO MD. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-30-70		24C. NAME OF CEMETERY or CREMATORY OAK LAWN	
24D. LOCATION (City, town, or county) (State) BALTO. CO., MD		25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970			
25B. NAME OF REGISTRAR W. E. Taylor, M.D.		25C. FUNERAL DIRECTOR W. E. Taylor, M.D.			



70 7523

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

70 7523

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

William Wharton

2. DATE AND HOUR OF DEATH

7/27/70

540 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Baltimore City Hospitals
4940 Eastern Ave.
Baltimore, Md. 212244. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

3311 Mondawmin Ave

21216

007

5. SEX

Male

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

10-18-92

9. AGE (in years
last birthday)

77

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Wharton

14. MOTHER'S MAIDEN NAME

Maggie Rue

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

16. SOCIAL
SECURITY NO.

705-10-9241

17. INFORMANT

4940 Eastern Ave.

ADDRESS

BCH Records: Baltimore, Md. 21224

18.

1990 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenio, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

metastatic Ca

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

6 months

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

7/16/70

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

diagnosis

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

no

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

no

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

1(Month) 1(Day) 1(Year) 1(Hour)

21E. INJURY OCCURRED

While At ☐Not While ☐

Work

At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/11/1970 to 7/27/70
that (H) (we) last saw the deceased alive on 7/27/70 and that (M) (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ronald Blum

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7/27/70

23C. PHYSICIAN'S
NAME (Type)

Ronald Blum M.D.

DEGREE

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Ave. Baltimore, Md. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-31-70

24C. NAME OF CEMETERY OR CREMATORY

London Pk. Nat'l.

24D. LOCATION

(City, town, or county)

Balto. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 30 1970

25B. NAME OF REGISTRAR

R. E. Bailey, Jr.

25C. FUNERAL DIRECTOR

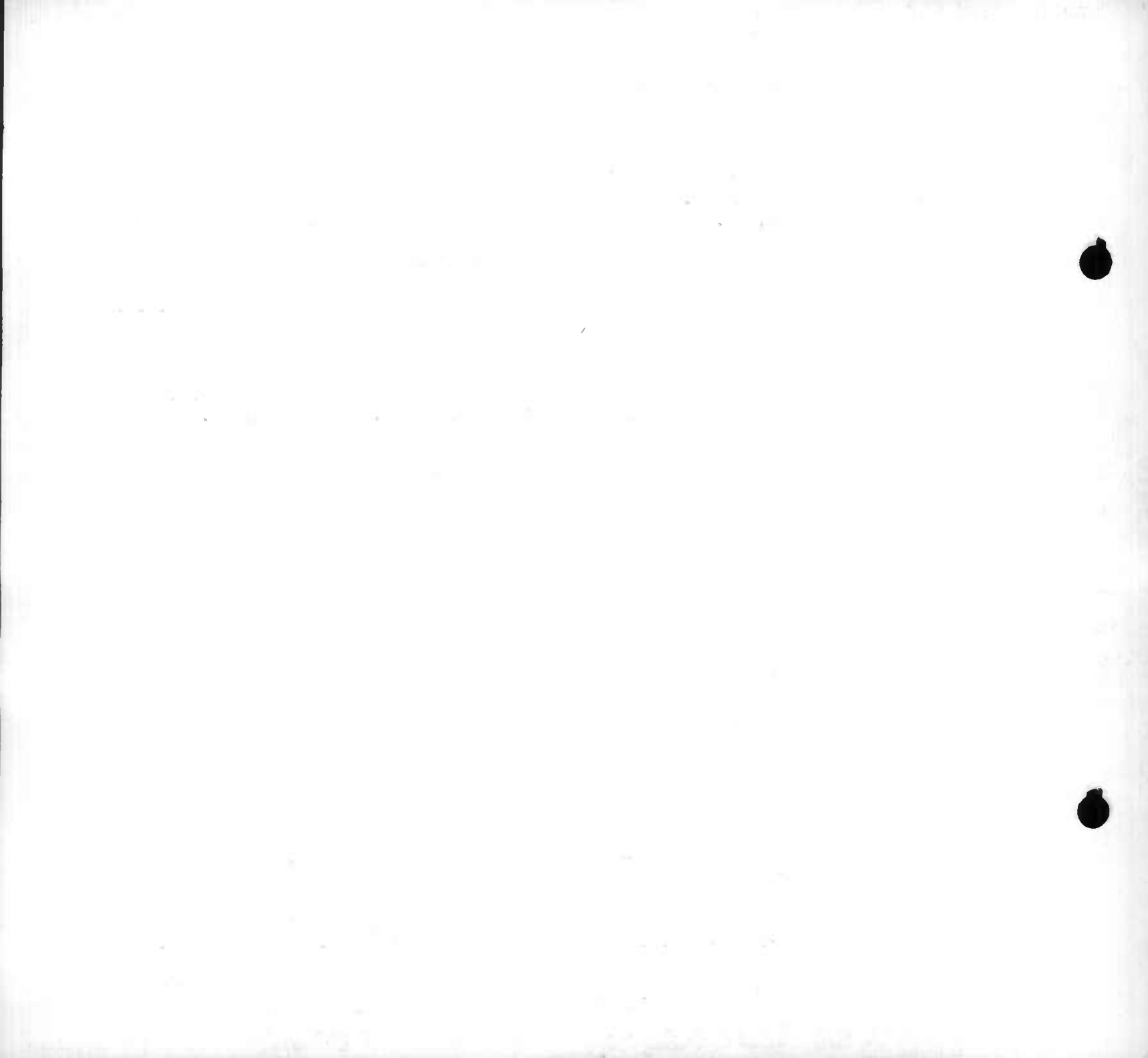
V. BAILEY

ADDRESS

Kelson F.H. 1348 CALHOUN ST.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-600		70 7524		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7524	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) TERRY, George				7/28/70 9:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
33 The Johns Hopkins Hospital				Maryland			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				19 N. Bentalou Street			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	
Male	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	3/3/21	49			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		Towson State Coll.		Md.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Paul Terry				Irene Washington			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		219-07-0700		Dorothea Reinat 19 N. Bentalou St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE ? CVA			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Malignant hypertension			
				DUE TO, OR AS A CONSEQUENCE OF:			
				(C) renal disease (chronic glomerulonephritis)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <u>July 7</u> 19 <u>70</u> to <u>July 28</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>July 28</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
<u>Steven R. Austin, M.D.</u>				7/28/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
STEVEN R. AUSTIN, M.D.				550 N. BROADWAY, BALTIMORE, MD			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-1-70		New Cathedral Cem.		Balt. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JUL 30 1970		Robert E. Taylor, M.D.		V. Bailey Kelson F.H. 1348 Calhoun St.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7525

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Melvin Faulkner

2. DATE
OF
DEATHKnown ☐
Estimated ☐Month
7Day
26Year
70Hour
6:15 p. m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OF DECEASED)

Lutheran Hospital 8-7-70

3. DATE
PRONOUNCED DEADMonth
7Day
26Year
70Hour
6:15 p. m.

5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)

A. STATE

Md.

B. COUNTY

1607

6. SEX

male

7. RACE

Negroid

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

12-21-18

10. AGE (in years
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1505 N. Hilton St.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Odis Faulkner

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Cora Gross

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Willie Faulkner 819 Wildwood Pkwy.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Fractured neck

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

unk. Home

22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?

unk. 1505 N. Hilton St.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

7-26-70

22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

unk. Fell off wall while intoxica-
ted

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ ~~Death by medical or dental instrument~~ ☒ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

7/27/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-30-70

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 30 1970

25B. NAME OF REGISTRAR

Robert E. Fabe, M.D.

25C. FUNERAL DIRECTOR

V. Bailey ADDRESS

Kelson FH. 1348 Calhoun St.

CERTIFICATE AMENDED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-200		70 7526		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7526	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HERMAN LEWIS				2. DATE AND HOUR OF DEATH 7-28-70 11:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2037			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND HOSPITAL REDWOOD AND GREENE STS. BALTO. MD.				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M 6. RACE N. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 7-27-15		9. AGE (In years last birthday) 55	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
13. FATHER'S NAME Willie Lewis				14. MOTHER'S MAIDEN NAME Eula			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK. NO				16. SOCIAL SECURITY NO. 829-07-330		17. INFORMANT ELLA LEWIS ADDRESS 508 MT. HOLLY ST. BALTO. MD. 21229	
18. 25091 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE CHF DUE TO, OR AS A CONSEQUENCE OF: ASCVD (B) Old anterior MI R/o acute MI DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jul. 24 1970 to Jul. 28 1970 that (I) (we) last saw the deceased alive on Jul. 28 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jaime F. Casellas M.D.				23B. DATE SIGNED 7-28-70		23C. PHYSICIAN'S NAME (Type) JAIME F. CASELLAS M.D.	
23D. ADDRESS UNIVERSITY OF MARYLAND HOSP				23E. FUNERAL DIRECTOR Kelson F. H. Bailey ADDRESS 1348 Calhoun St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 731-70		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Kelson F. H. Bailey ADDRESS 1348 Calhoun St.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7527

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM T. COLLINS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour July 28, 1970 11:50 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTIMORE		C. CITY OR TOWN Baltimore	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH SEPT. 1, 1889		10. AGE (In years last birthday) 80	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM COLLINS		14. STREET AND NUMBER 5200 Greenwich Avenue	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POSTMAN		14B. KIND OF BUSINESS OR INDUSTRY U.S. POST OFFICE	
15. MOTHER'S MAIDEN NAME ELLA DOWLING		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 41241		18. INFORMANT MRS. LILLIAN COLLINS ABOVE ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 8/1/70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/29/70	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/1/70	
24C. NAME of CEMETERY or CREMATORY CREST LAWN		24D. LOCATION (City, town, or county) (State) HOWARD COUNTY MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970		25B. NAME of REGISTRAR Robert E. Kelly	
25C. FUNERAL DIRECTOR McCULLY		ADDRESS 130 E FORT AVENUE	

1917

MEMBER

AMERICAN MEDICAL ASSOCIATION

CHICAGO, ILL.

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CHICAGO, ILL.

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BALTIMORE CITY HEALTH DEPARTMENT				70 7528			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				70 7528			
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) Oehm Florence O. Koch				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 7 26 70 12:48 p.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ADDRESS OR LOCATION 2715 E. Jefferson St. 8-3-90				3. DATE PRONOUNCED DEAD Month Day Year Hour 7 26 70 12:48 p.m.			
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Nd. B. COUNTY 602							
6. SEX Female		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH May 23, 1931		10. AGE (In years last birthday) 39		11. BIRTHPLACE (State or foreign country) Baltimore		E. STREET AND NUMBER 2715 E. Jefferson St.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Edward J. Smith		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Margaret Simmons	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT Margaret McKenna, mother, 3147 Elmora Av		ADDRESS 3147	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cirrhosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/27/70							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/30/70		24C. NAME of CEMETERY or CREMATORY Mt. Carmel Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane			

VS 153 8-3-70 M.H.

ORIGINAL FILED

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7529	
<p>BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>LUTZ, RUBY Evelyn</u></p>		<p>2. DATE AND HOUR OF DEATH <u>7/26/70</u> <u>7:30 P.</u> M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>49 North Charles Gen. Hosp.</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2633</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3045 Mayfield Ave. Balt., Md.</u></p>			
<p>5. SEX <u>F</u></p>	<p>6. RACE <u>W</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>3-12-94</u> <u>76</u> AGE (In years last birthday) <u>76</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>Baltimore MARYLAND</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <u>us</u></p>		<p>13. FATHER'S NAME <u>John R. Osborn</u></p>			
<p>14. MOTHER'S MAIDEN NAME <u>Lulu Greenfield</u></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p>			
<p>16. SOCIAL SECURITY NO. <u>219-26-2008</u></p>		<p>17. INFORMANT <u>NCGH - Chart</u></p>		<p>ADDRESS <u>Balto. Md.</u></p>	
<p>18. CAUSE OF DEATH</p>					
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><u>Conclusive Heart failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Ch. Glomerulonephritis, Arterio</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes Mellitus</u> (C)</p>			
<p>II</p>					
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>					
<p>19A. DATE OF OPERATION <u>2</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <u>Yes</u></p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>			
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>7/8/70</u> to <u>7/26/70</u>, that (I) (we) last saw the deceased alive on <u>7/26/70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <u>Ninevah R. Aranas</u></p>				<p>23B. DATE SIGNED <u>7/28/70</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>NINEVAH R. ARANAS</u></p>				<p>23D. ADDRESS <u>North Charles Gen. Hospital</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>7/30/70</u></p>		<p>24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith</u></p>	
<p>24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u></p>		<p>25A. DATE REC'D BY HEALTH DEPT. <u>JUL 30 1970</u></p>			
<p>25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u></p>		<p>25C. FUNERAL DIRECTOR <u>Schmunk R. 333 Rehm Lane</u></p>			

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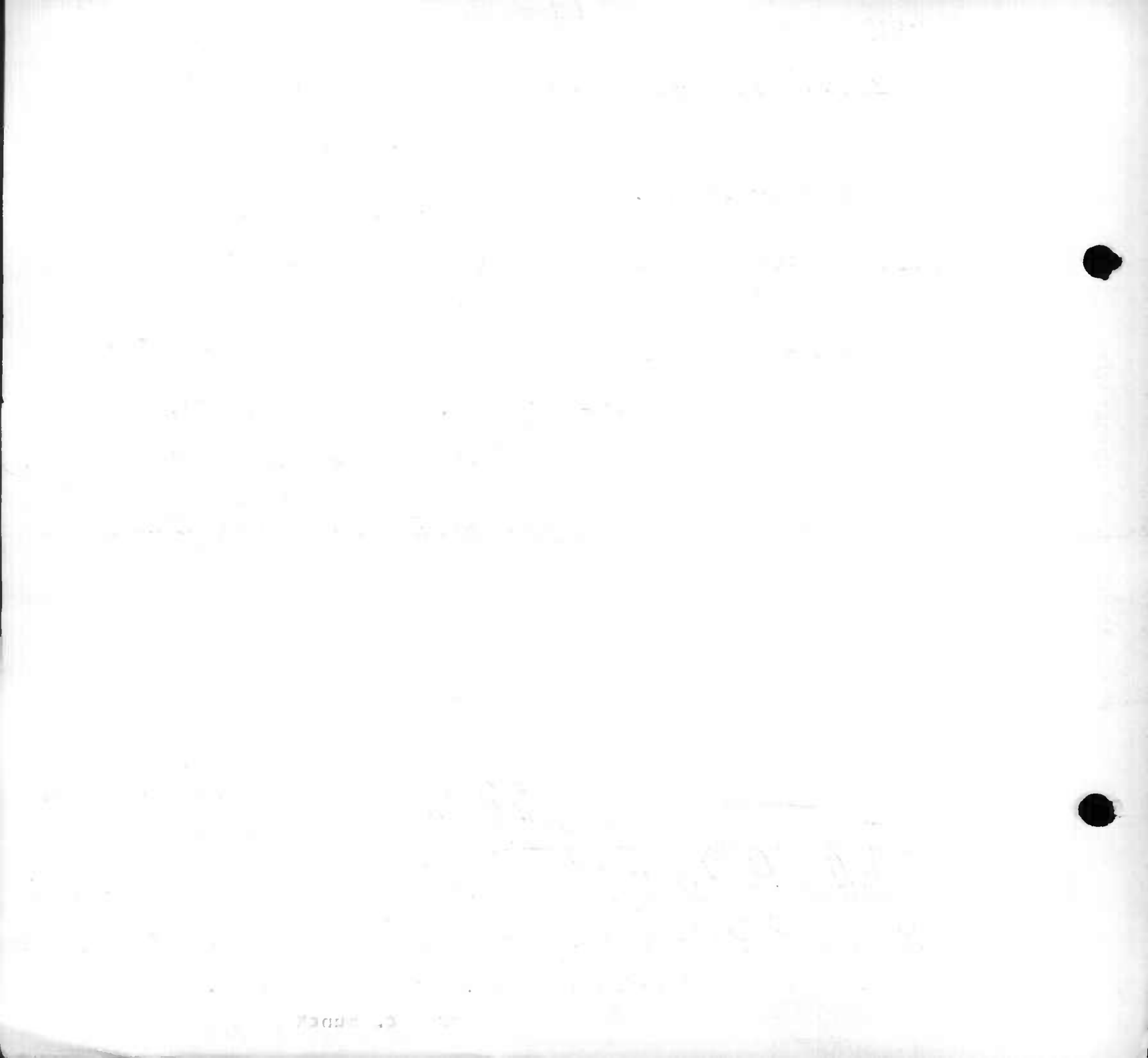
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-416 70 7530				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 7530	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
		LOYDEMA WILBURN		July 26, 1970 7:20 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY			
				Md. 21213		2643			
00 3751 Lyndale Ave.				C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER					
				3751 Lyndale Avenue					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	If Under 1 Yr. Months		If Under 24 Hrs. Days	
female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	1/26/88		82				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
unknown					Virginia				
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
UNKNOWN Calton				unknown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS
			228-09-3774D		Mrs. Nelson Durham, dght, above				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				12 years	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 20 1965 to July 26 1970 that (I) (we) lost saw the deceased alive on July 24 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
MELVIN F. POLEK, M.D.				July 27, 1970					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
MELVIN F. POLEK, M.D.				3003 Belair Road Balto, Md 21218					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		7/29/70		Clinch Valley Mem. Cem.		Richmond, Va.			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR		ADDRESS	
JUL 30 1970			John C. Vanecko, Jr.			Schimunek Funeral Home		3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-652 70 7531		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7531	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) VanVard Mildred V. Cernik		2. DATE AND HOUR OF DEATH 7-26-70 1:50 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		C. CITY OR TOWN BALTIMORE		E. STREET AND NUMBER 4104 BRENDON AVE	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02 22 03	9. AGE (in years last birthday) 67	10. CITIZEN OF WHAT COUNTRY? Maryland
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME CHARLES JANSEN		14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 214-24-6265		17. INFORMANT ADDRESS Patricia Sonneborn, dght, above			
18. 41019 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCTION (B) ASCVD (C) GI bleed		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (we) (this hospital) attended the deceased from 6-1 19 70 to 7-26 19 70 that (we) lost saw the deceased alive on 7-26-70 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anthony Jackson		23B. DATE SIGNED 7-26-70		23C. PHYSICIAN'S NAME (Type) ANTHONY JACKSON M.D. DEPT. OF MED. JOHNS HOPKINS HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/29/70		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, MD	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25D. ADDRESS			

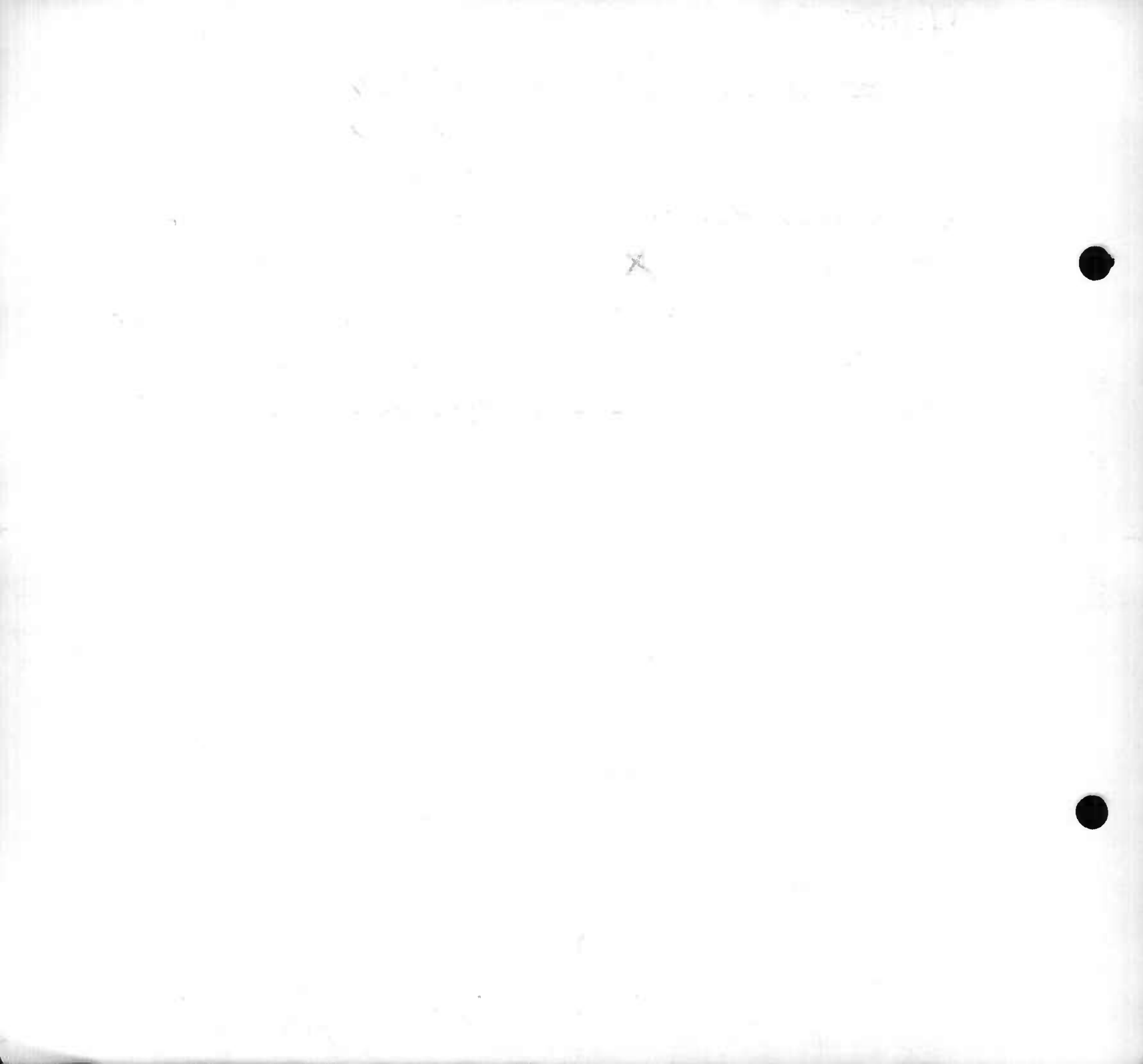
YE

Brendan Ave.

FUNERAL DIRECTOR: IMPORTANT

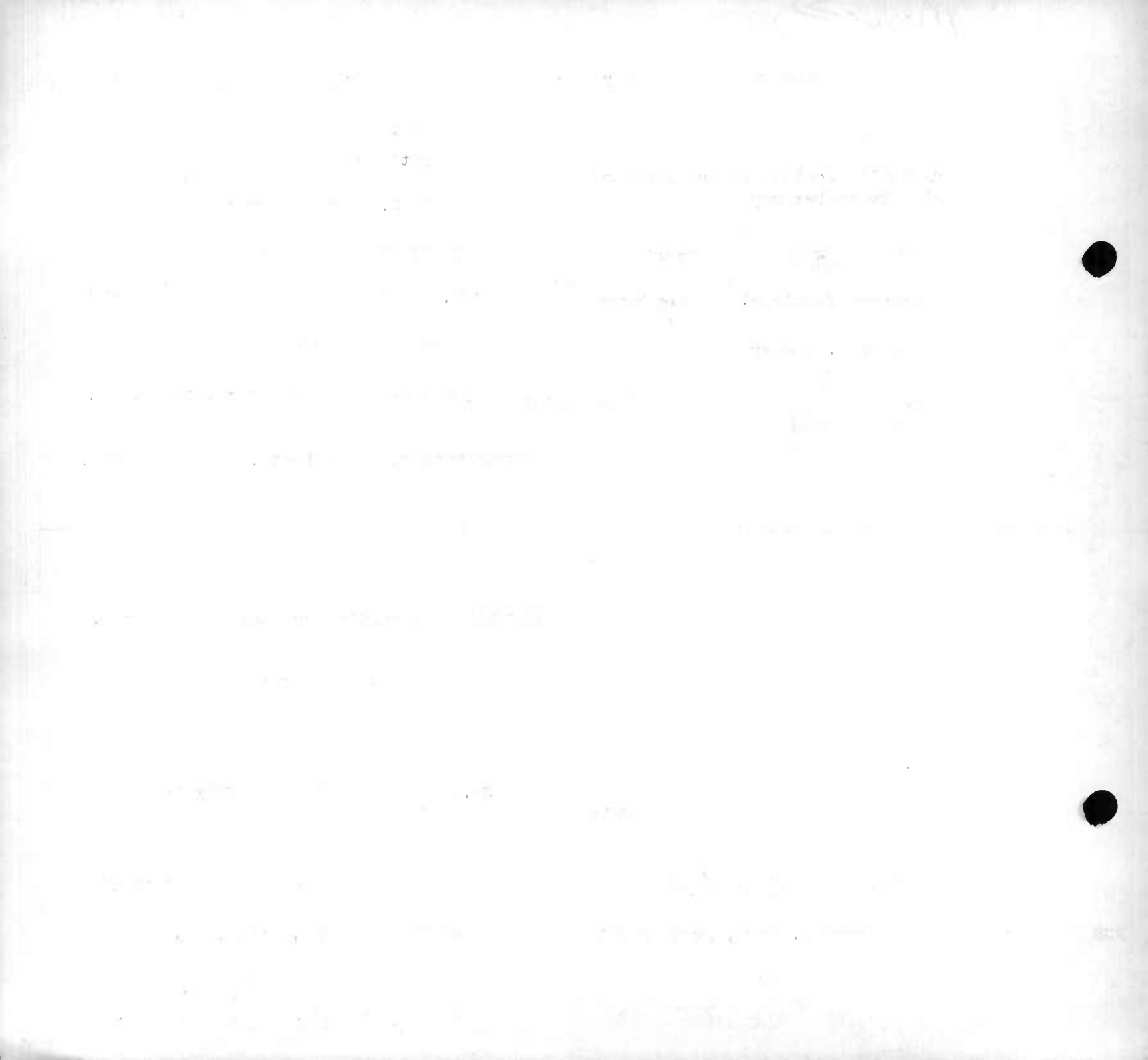
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 7532</u>	
H-155 70 7532		BIRTH NO. <u>70 7532</u>	
1. NAME OF DECEASED (Type or Print) <u>Hofmann, Mrs. Edna P.</u>		DATE AND HOUR OF DEATH <u>07-27-70 1:30 p.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Bon Secours Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>21211</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bon Secours Hospital</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>W</u>		E. STREET AND NUMBER <u>1401 Morling Avenue</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/28/96</u> 9. AGE (In years last birthday) <u>73</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Richter's</u>	
11. BIRTHPLACE (State or foreign country) <u>Williamsport, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Pettit, John</u>		14. MOTHER'S MAIDEN NAME <u>Ella E. Hall</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-12-6992</u>	
17. INFORMANT <u>Admission Sheet</u>		ADDRESS <u>Hammond Hofmann, son, above</u>	
18. <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Ac. Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Diabetes mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>	
20A. AUTOPSY? (Yes or No) <u>-</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>-</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>		21D. TIME OF INJURY (APPROX.) <u>-</u>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>07/24</u> 19 <u>70</u> to <u>07/27</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>07/27</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Kusuma K. Pruksapong M.D.</u>		23B. DATE SIGNED <u>7/27/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. KUSUMA K. PRUKSAPONG M.D.</u>		23D. ADDRESS <u>Bon Secours Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/30/70</u>	
24C. NAME of CEMETERY or CREMATORY <u>Meadowridge Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 30 1970</u>		25B. NAME OF REGISTRAR <u>John E. Fisher, Jr.</u>	
25C. FUNERAL DIRECTOR <u>Behimund H. 3331 Belvoir Lane</u>		ADDRESS <u>-</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-500 70 7533		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 7533	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				Herman Joseph Mooney Sr.	
2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
July 26, 1970, 11:50 P.M.		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.	
		US Public Health Service Hospital 3100 Wyman Parkway		B. COUNTY 101	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)			
Baltimore		835 S. Kenwood Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	(If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.)
M	W	Married	12/21/11	58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Engineer (retired)		Seafarer		Md. Baltimore	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
USA		John C. Mooney		Laura Mc Donald	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		705-12-6059		Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Herpes zoster, disseminated		2 wks.	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II		Chronic lymphocytic leukemia		2 yrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
yes		yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 20 19 70 to July 26 19 70, that (I) (we) last saw the deceased alive on July 26 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Samuel P. Ward M.D.				7/27/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Samuel P. Ward, Surgeon (R)		US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/31/70		Oak Lawn Cemetery	
24D. LOCATION (City, town, or county)		24E. ADDRESS (State)			
Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 30 1970		Robert E. Farber, M.D.		Schimunek Funeral Home, Inc. 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7534</u>	
BIRTH NO. <u>W-300</u>		70 7534		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>JULIA A. WHITE</u>			2. DATE AND HOUR OF DEATH <u>26 July 1970</u> <u>10-20 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Baltimore, Maryland</u> B. COUNTY <u>2642</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u> <u>44 BALTIMORE, MARYLAND 21218</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>4703 H Parkside Gardenway</u> <u>Baltimore, Maryland 21206</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>07-13-99</u>	9. AGE (in years last birthday) <u>71 yrs</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> <u>Baltimore</u>
12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>			13. FATHER'S NAME <u>Robert Galster</u>		
14. MOTHER'S MAIDEN NAME <u>Annie Kahl</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>Unknown</u>		
16. SOCIAL SECURITY NO. <u>218-10-6888</u>			17. INFORMANT <u>4032 Elmora Ave.</u> ADDRESS <u>21213</u> <u>Mrs. Anna E. McNamara, dght.</u>		
18. <u>44571</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Septicemia</u>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Gangrene Right arm and both feet</u>			(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Renal failure</u>					
19A. DATE OF OPERATION <u>06/22/1970</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Septicemia Gangrene and suppuration Right arm and forearm</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 11 - 1970</u> to <u>July 26 - 1970</u> that (I) (we) last saw the deceased alive on <u>26th July 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Y. K. Shetty</u>			23B. DATE SIGNED <u>26 July 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>Y. K. SHETTY</u>
23D. ADDRESS <u>Union Memorial Hospital</u> <u>Baltimore, Maryland</u>			23E. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/30/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>	
24D. LOCATION <u>Baltimore, Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JUL 30 1970</u>		24F. NAME OF REGISTRAR <u>Robert E. Galster</u>	

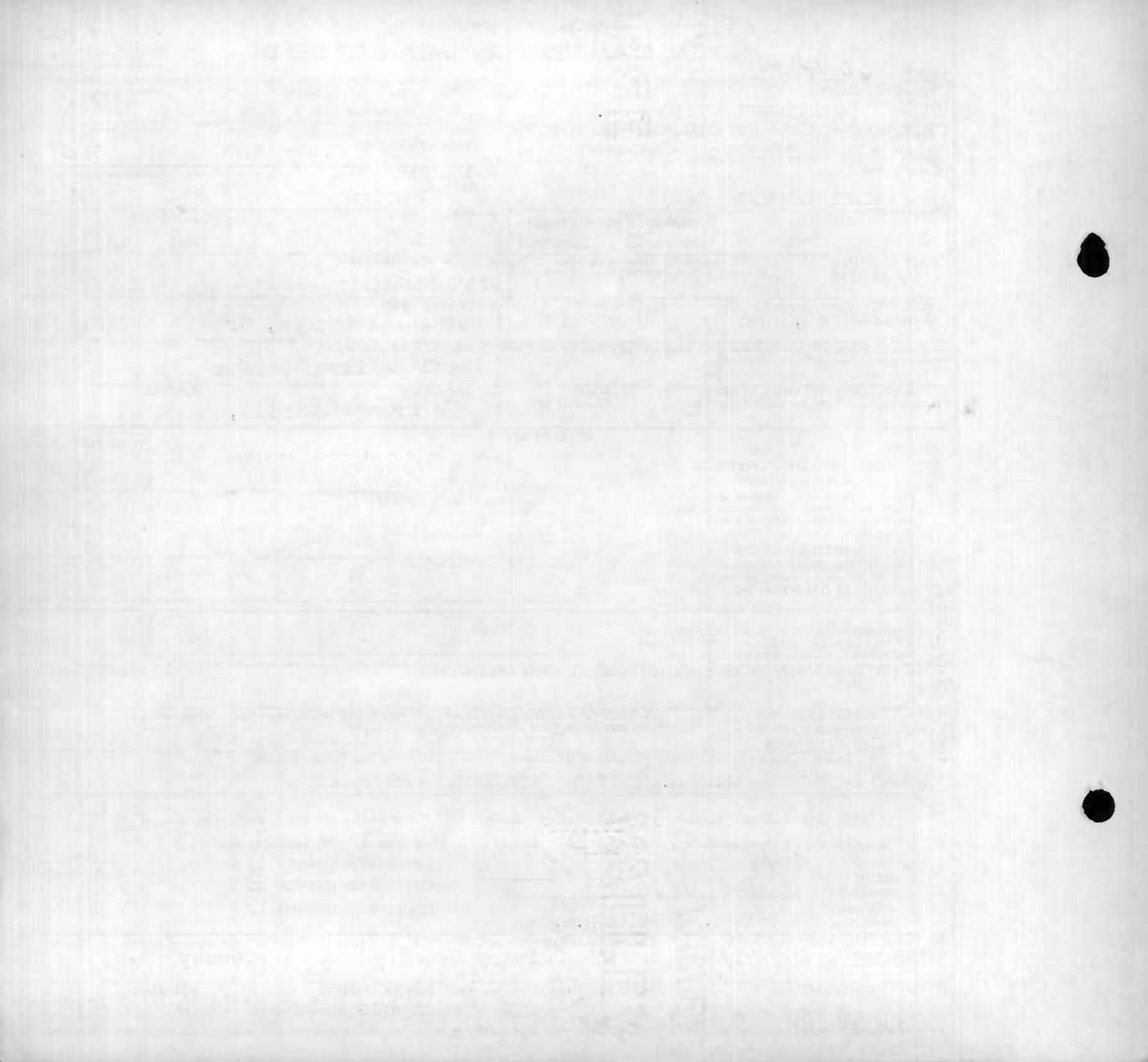


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 66-14835

REG. NO.

1. NAME OF DECEASED (Type or Print) NATHANIEL LEMMON, JR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour July 28, 1970 11:50 A.M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2798	
7. RACE Negro		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 5103 Lithfield Avenue	
9. DATE OF BIRTH 7/24/66		10. AGE (In years lost birthday) 4	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Nathaniel Lemmon, Sr		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Lardi Malissa Purdue	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT M's Brenda Murrill,		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Smoke and soot inhalation incident to conflagration (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 5103 Lithfield Avenue 2798			
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 7-28-70 11:34 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? conflagration			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 7/29/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/31/70	
24C. NAME OF CEMETERY or CREMATORY MT Calvary Cemetry		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	

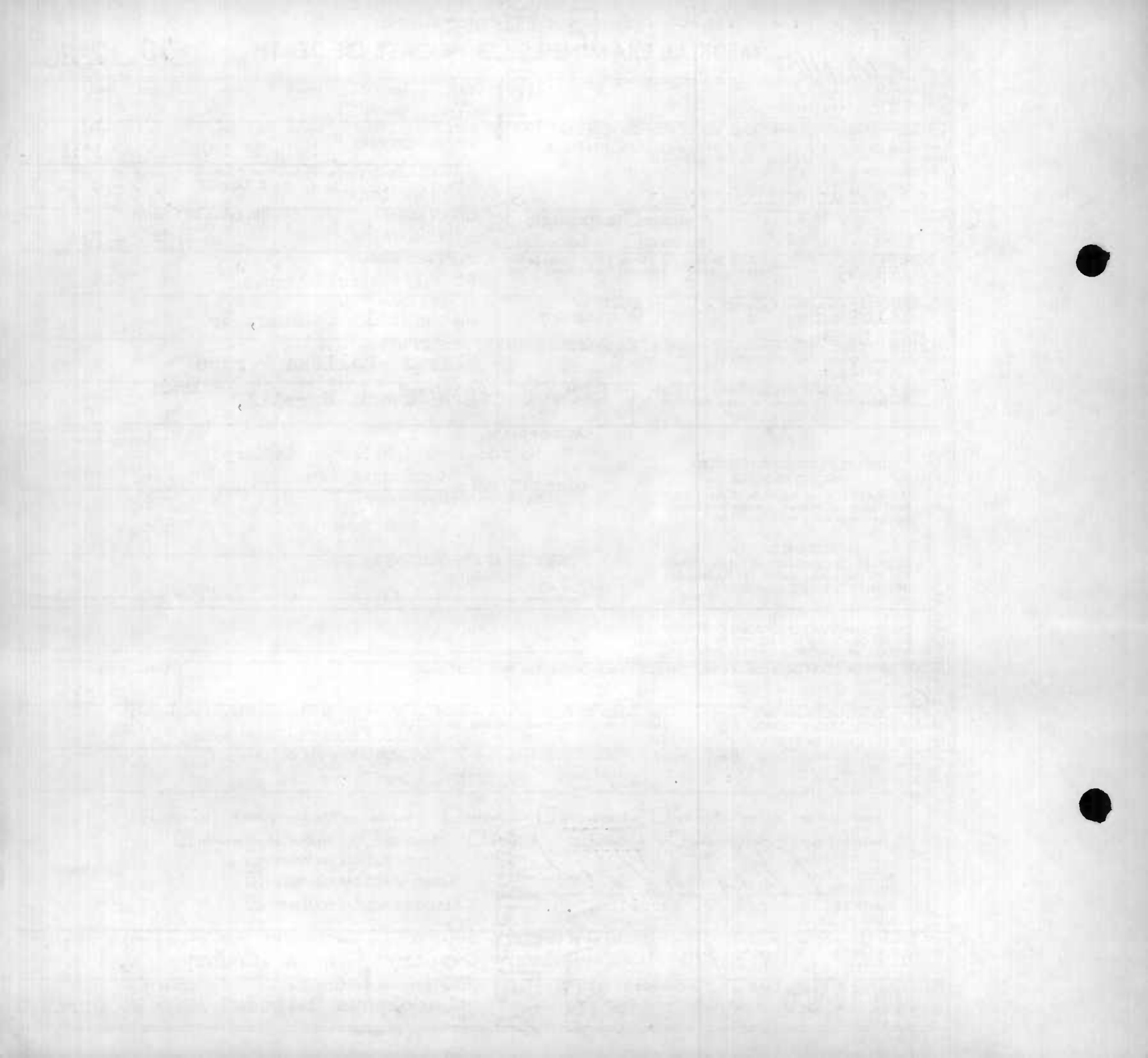


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7536

BIRTH NO. 69-11158

1. NAME OF DECEASED (Type or Print) CANDY LEMMON				2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL (DOA)				3. DATE PRONOUNCED DEAD Month Day Year Hour July 28, 1970 11:50 A.M.			
6. SEX Female				7. RACE Negro			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN Baltimore			
9. DATE OF BIRTH 6/23/69				10. AGE (In years last birthday) 1 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.			
11. BIRTHPLACE (State or foreign country) Baltimore Md				12. CITIZEN OF WHAT BOUNDARY?			
13. FATHER'S NAME Nathaniel Lemmon, Sr				14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2798			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				14B. KIND OF BUSINESS OR INDUSTRY			
15. MOTHER'S MAIDEN NAME Lardi Malissa Purdue				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
17. SOCIAL SECURITY NO.				18. INFORMANT Mrs Brenda Murrill, ADDRESS			
19. E890X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH Smoke and soot inhalation incident to conflagration (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) no							
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 5103 Litchfield Avenue 2798				22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 7-28-70 11:34 A.			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Conflagration			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/29/70							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/31/70			
24C. NAME OF CEMETERY or CREMATORY MT Calvary Cemetry				24D. LOCATION (City, town, or county) (State) A A County Md			
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			
25C. FUNERAL DIRECTOR Adolphus Halstead				ADDRESS 1206 W North A			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

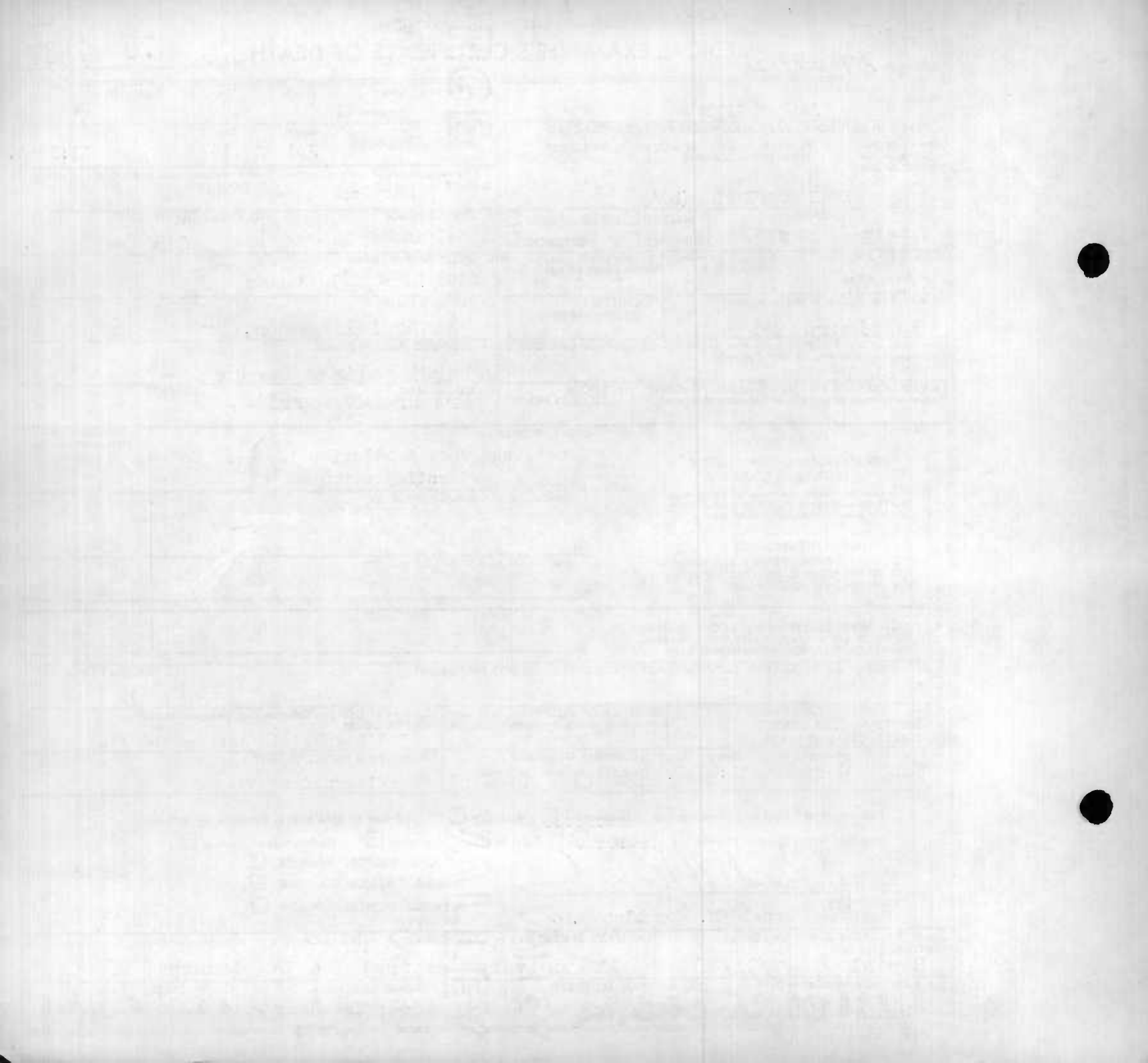
REG. NO.

70 7537

BIRTH NO.

67-09712

1. NAME OF DECEASED (Type or Print) CAROLYN LEMMON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour July 28, 1970 11:50 A.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 5/20/67		10. AGE (In years lost birthday) 3	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? U S A	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs Brenda Murril,		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E-8904 Smoke and soot inhalation incident to conflagration (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 5103 Litchfield Avenue 2798		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 7-28-70 11:34 A.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Conflagration	
23. I certify that I held an inquiry <input type="checkbox"/> inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/29/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/31/70	
24C. NAME OF CEMETERY or CREMATORY MT Calvary Cemetry		24D. LOCATION (City, town, or county) (State) A A County M	
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970 Robert E. Farley, M.D.		25B. NAME OF REGISTRAR Adolphus Halstead 1206 W north Av	



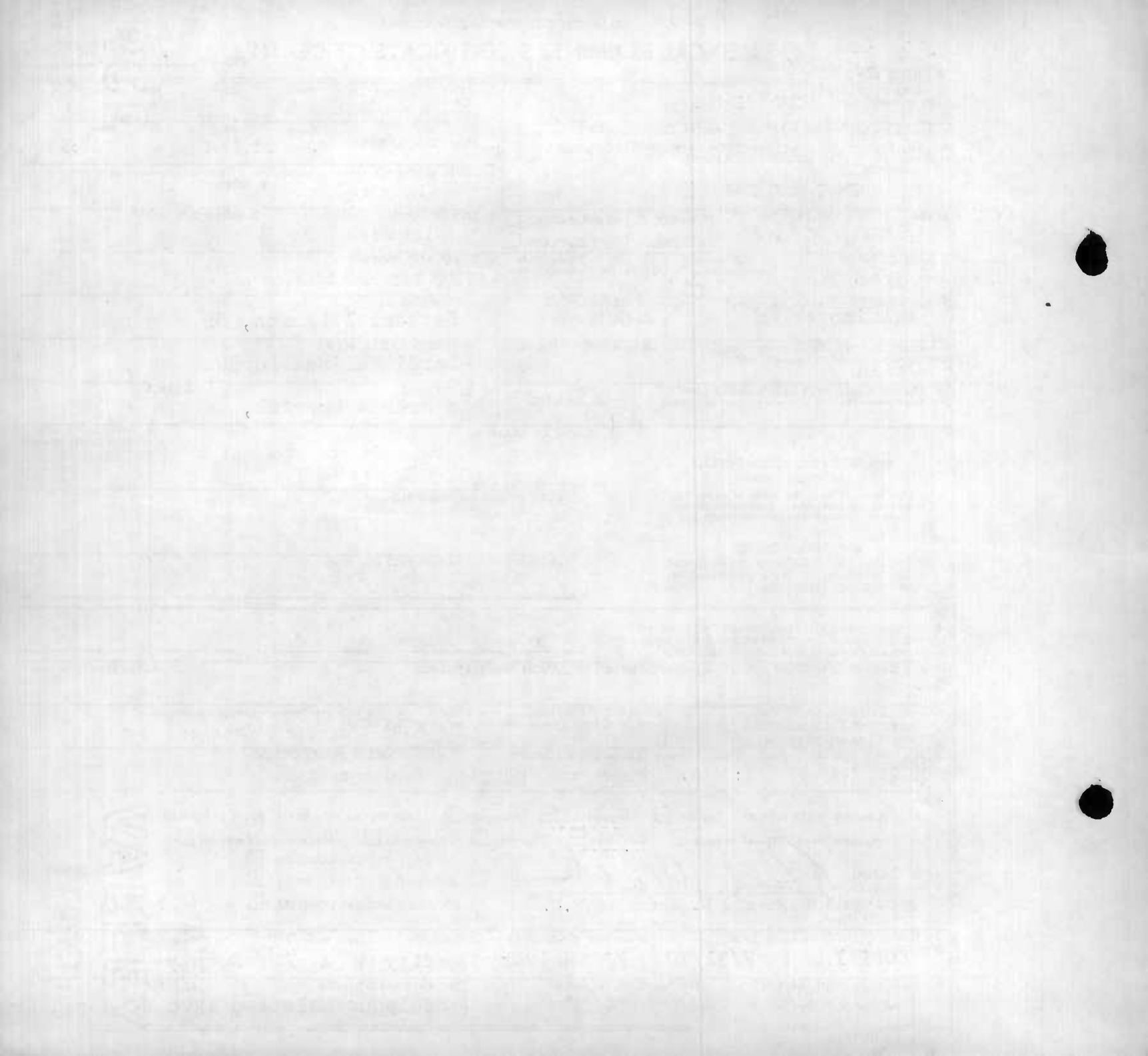
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 7538

BIRTH NO. 68-10564

1. NAME OF DECEASED (Type or Print) STACEY LEMMON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour July 28, 1970 11:50 A. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 6/3/68		10. AGE (In years last birthday) 2 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Nathaniel Lemmon, Sr		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child	
15. MOTHER'S MAIDEN NAME Lardi Malissa Purdue		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT M s Brenda Murrill,	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E890X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH Smoke and soot inhalation incident to conflagration (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5103 Litchfield Avenue 2798		22D. TIME OF INJURY (APPROX.) 7-28-70 11:34 A.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Conflagration	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/29/70 ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/31/70	
24C. NAME of CEMETERY or CREMATORY M ¹ Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970 Robert E. Taylor, M.D.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/6B

V.S. 153

7-30-70

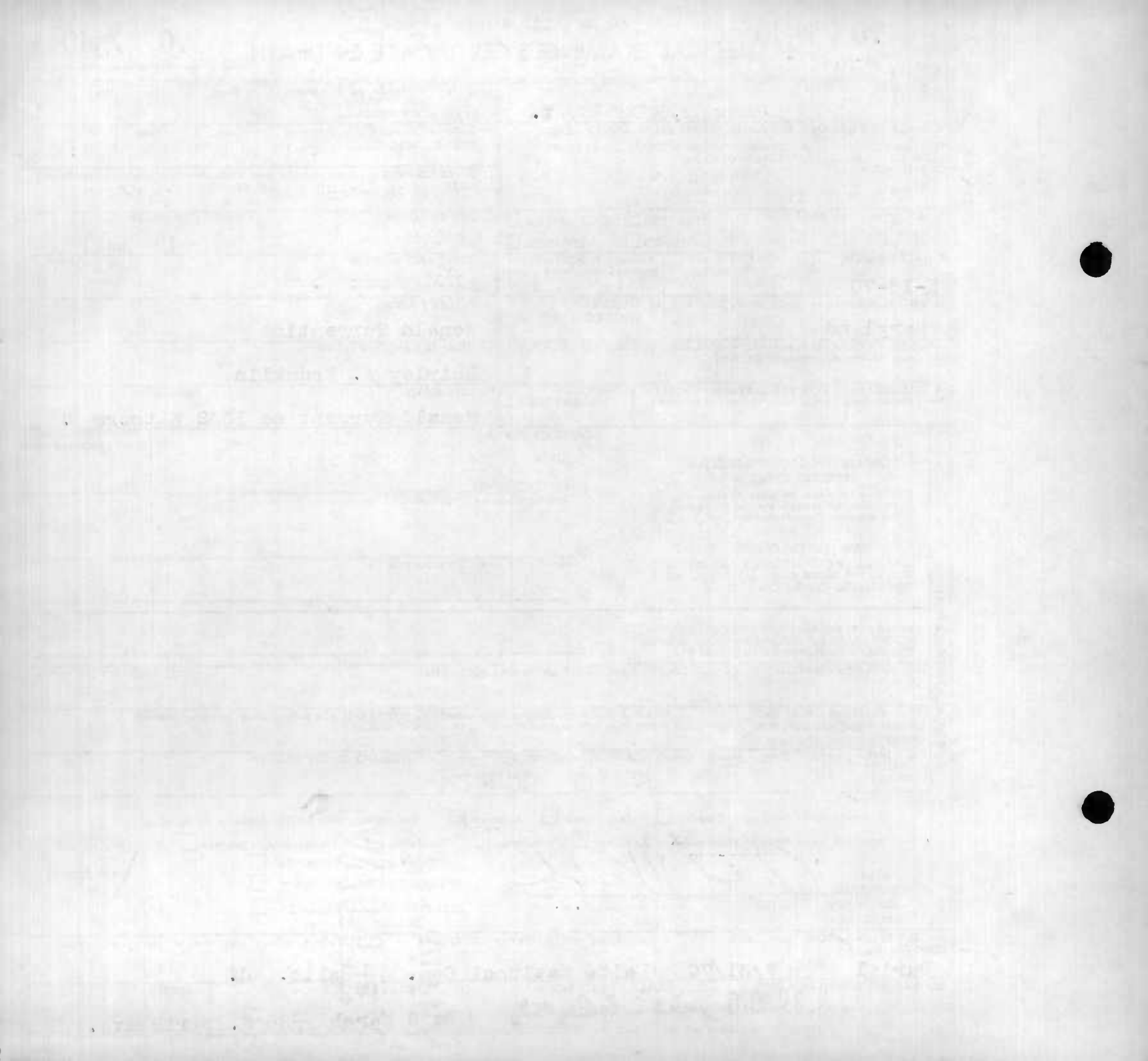
M.H.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) TURRENTINE, DIETRICH T.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION GOOD SAMARITAN HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour July 29, 1970 5:15 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 5-18-70		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 2		E. STREET AND NUMBER 1332 Kitmore Road	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ronald Turrentine		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Shirley A. Franklin		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Ronald Turrentine 1332 Kitmore Rd	
19. 795X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Sudden death in infancy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 7/29/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/31/70	
24C. NAME OF CEMETERY OR CREMATORY Balto National Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Wm C March		ADDRESS 928 E. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7541	
BIRTH NO. C-455 70 7541		1. NAME OF DECEASED (Type or Print) Mr. Charles S. Coleman		2. DATE AND HOUR OF DEATH 7/28/70 6:45 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secour Hospital		A. STATE Maryland		B. COUNTY 2003	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2004 Hollins Street			
5. SEX MALE	6. RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-1901	9. AGE (In years last birthday) 69	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
		10B. KIND OF BUSINESS OR INDUSTRY CHAIRMAN TRUCKING	11. BIRTHPLACE (State or foreign country) Richmond Va		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME 2111111111		14. MOTHER'S MAIDEN NAME Elizabeth Lawson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-01-8144		17. INFORMANT Address Colonel 2004 Hollins St	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		CVA		1 day	
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		Hypertensive ASCVD		years	
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
		Aspiration pneumonia			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/28/70 19 to 7/28 19 70 that (I) (we) last saw the deceased alive on 7/28 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kusuma K. Pruksapong M.D.		Attending <input type="checkbox"/> Phys. Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/28/70	
23C. PHYSICIAN'S NAME (Type) Dr. KUSUMA K. PRUKSAPONG M.D.		23D. ADDRESS Bon Secours Hospital			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 8/3/70		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn	
				24D. LOCATION (City, town, or county) (State) Baroda Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970		25B. NAME OF REGISTRAR Robert E. Faber M.D.		25C. FUNERAL DIRECTOR William P. Hays 636 N. Green St	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-600 70 7542		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 7542	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BEATRICE V. SQUARE		2. DATE AND HOUR OF DEATH 7/26/70 1:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If NOT in HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission) A. STATE MD. B. COUNTY 2101		C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE N 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/28/04 9. AGE (In years last birthday) 65		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Domestic Pur Family		10B. KIND OF BUSINESS OR INDUSTRY BALTO		11. BIRTHPLACE (State or foreign country) BALTO	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Shidowen	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Univ. Hosp. Clinical Brief. ADDRESS	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Stroke CVA		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Intraabdominal abscess, RLQ, drained				14 days	
19A. DATE OF OPERATION 3/16/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED abdominal abscess		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 7/16/70 19 to 7/26/70 19		that (I) was last saw the deceased alive on 7/26/70 19 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.	
23A. SIGNATURE Karl F. Meachy Jr MD		23B. DATE SIGNED 7/26/70		23C. PHYSICIAN'S NAME (Type) KARL MEACHY	
23D. ADDRESS University Hosp		24A. BURIAL CREMATION, REMOVAL (Specify) Burned		24B. DATE 7/30/70	
24C. NAME OF CEMETERY OR CREMATORY not cemetery		24D. LOCATION (City, town, or county) Brownhays D.R. Co MD		(State)	
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor MD		25C. FUNERAL DIRECTOR Arnold R. Hughes 2387 gettysburg st	
25D. ADDRESS					

1000

Domestic Political Economy
1114

Domestic Political Economy
1114

A-450 70 7543		BALTIMORE CITY HEALTH DEPARTMENT	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 7543	
BIRTH NO.		2.	
1. NAME OF DECEASED (Type or Print) VIOLA FORBES ALLEN		DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 122 S. Scott Street		3. DATE PRONOUNCED DEAD Month Day Year July 28, 1970 Hour 6:55 A. M.	
6. SEX Female		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1803	
7. RACE Negro		C. CITY OR TOWN Baltimore	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 9-7-1897		E. STREET AND NUMBER 122 S. Scott Street	
10. AGE (In years last birthday) 72		11. BIRTHPLACE (State or foreign country) Baltimore MD	
12. CITIZEN OF USA		13. FATHER'S NAME Phillip Forbes	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		15. MOTHER'S MAIDEN NAME Ida Gross	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Victoria Allen 122 Scott St		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Uremia due to chronic renal failure			
20A. DATE OF OPERATION		21. AUTOPSY? (Yes or No) no	
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 7/28/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/31/70	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Thompson & Sons 635 H g m m		ADDRESS	

9-7-1897 75

Barro md

WMA

Homestead

at Home

no

Philip Forest

Lee Cross

Victoria Allen 122-2-14

Burns 18/10/1897

London 18/10/1897

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620 70 7544				BALTIMORE CITY HEALTH DEPARTMENT		70 7544	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) BRISCO-BROOKLYN				2. DATE AND HOUR OF DEATH 7-27-70 11230X P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Ind. B. COUNTY 301			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The John Hopkins				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 349 Kerring Court							
5. SEX M	6. RACE N.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/30/96	9. AGE (in years last birthday) 73	If Under 1 Yr. Months	If Under 24 Hrs. Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Longshoreman Port of Baltimore				10B. KIND OF BUSINESS OR INDUSTRY St Mary Co MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edgar Briscoe				14. MOTHER'S MAIDEN NAME Nora Smith			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI 2/13-01-1969				16. SOCIAL SECURITY NO. 213-01-1569			
17. INFORMANT Estelle Brown				ADDRESS 305 N CALHOUN ST			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cardiovascular collapse (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Metabolic & respiratory acidosis (C) Pulmonary emboli postoperatively Carol Ligaton Whipple procedure for Cancer duodenum				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Whipple procedure for Cancer duodenum							
19A. DATE OF OPERATION 4/30/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA duodenum		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indify medical examiner) 8		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 8		21C. WHERE DID INJURY OCCUR? 8		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 8		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? 8			
22. I certify that (this hospital) attended the deceased from 4-17 19 70 to 7-27 19 70 that (I) (we) last saw the deceased alive on 7-27-70 at 7 AM and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Hugh Robinson MD				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-27-70	
23C. PHYSICIAN'S NAME (Type) Hugh Robinson, M.D.				23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/31/70		24C. NAME OF CEMETERY OR CREMATORY Landon Park National		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970		25B. NAME OF REGISTRAR Rebecca E. Taylor, MD		25C. FUNERAL DIRECTOR Marshall P. Hays		ADDRESS 638 N 9th St	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7545	
BIRTH NO. M-240 70 7545		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) McCauley Joseph (JOE F. McCAULEY)		2. DATE AND HOUR OF DEATH 7/28/70		5:50 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		B. COUNTY 1304	
Granada Nursing Home Liberty Hts Ave		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2311 Bryant Ave			
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-16-06	9. AGE (In years last birthday) 64	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tenn	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jesse McCauley		14. MOTHER'S MAIDEN NAME Willie Pickett	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II		16. SOCIAL SECURITY NO. 454-03-3075		17. INFORMANT Medical Records (Granada) 4017 Liberty Hts	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARCINOMA OF STOMACH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/25/70 19 to 7/28/70 19 that (I) (we) last saw the deceased alive on 7/28/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) HARRIS DEUNARINE	
23D. ADDRESS		23E. ADDRESS		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-31-70		24C. NAME OF CEMETERY OR CREMATORY Loudon Park	
24D. LOCATION		24E. LOCATION		24F. LOCATION	
Baltimore, Maryland		Baltimore, Maryland		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor MD		25C. FUNERAL DIRECTOR Mary-Elizabeth Law - 802 Madison Ave.	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 70 7546

BIRTH NO. 70-12415 7546

1. NAME OF DECEASED
(Type or Print)

PATTERSON, BABY BOY

2. DATE AND HOUR OF DEATH

JULY 25, 1970

3:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

40 ST. AGNES HOSPITAL
WILKENS & CATON AVENUES
BALTIMORE, MARYLAND 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

21061

ANNE ARUNDEL CO

C. CITY OR TOWN

GLEN BURNIE

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

21 SCOTT AVENUE

5200

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED ☐

NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

07-22-70

9. AGE (In years
last birthday)

If Under 1 Yr.
Months

If Under 24 Hrs.
Days

If Under 24 Hrs.
Hours Min.

2 21 20

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

INFANT

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

STANLEY PATTERSON

14. MOTHER'S MAIDEN NAME

AMANDA ROSS

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

BALTIMORE, MD. #21229

ST. AGNES HOSP. RECORDS-WILKENS & CATON

18. 5-69-91

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardio respiratory failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) Hypertension

DUE TO, OR AS A CONSEQUENCE OF:

(C) Cancerous Bowel

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., In or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from JULY 22, 19 70 to JULY 25, 19 70
that (X) (we) last saw the deceased alive on JULY 25, 19 70 and that in (X) (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.

23A. SIGNATURE

BALG

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

07-27-70

23C. PHYSICIAN'S
NAME (Type)

MIRZA BALG MD.

23D. ADDRESS

CATON & WILKENS AVE. BALTO MD. 21229

24A. BURIAL CREMATION
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUL 30 1970

Robert E. Taylor, Jr.

Joseph B. Locks

1304 N Central

1. The first part of the report is a general
 introduction to the subject of the study.
 2. The second part is a description of the
 methods used in the study.
 3. The third part is a description of the
 results of the study.
 4. The fourth part is a discussion of the
 results of the study.
 5. The fifth part is a conclusion of the study.
 6. The sixth part is a list of references.
 7. The seventh part is a list of figures.
 8. The eighth part is a list of tables.
 9. The ninth part is a list of appendices.
 10. The tenth part is a list of footnotes.

1. The first part of the report is a general
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 8. The eighth part is a list of tables.
 9. The ninth part is a list of appendices.
 10. The tenth part is a list of footnotes.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-345 70 7547				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7547	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>PAYNE Mary Gatling</u>				2. DATE AND HOUR OF DEATH <u>7/28/70</u> <u>5:50 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Bottom Hill Nursing Home</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1002</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bottom Hill Nursing Home</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>903 W. Eden St</u>			
5. SEX <u>7</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/12/96</u>	9. AGE (In years last birthday) <u>73</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Mary Jones</u>			
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>214-56-5378</u>		17. INFORMANT <u>James Mayo 2722 Hugo Ave</u>	
18. <u>15-4-11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CA / system with relations</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4/69</u>	
				(B) <u>arteriosclerosis per & disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>years</u>			
				(C) <u>arteriosclerosis, gen</u> DUE TO, OR AS A CONSEQUENCE OF: <u>years</u>			
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/23</u> 19 <u>70</u> to <u>7/28</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>7/28</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>7/29/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALLAN H. MACHAT MD</u>				23D. ADDRESS <u>2 E Red St Baltimore 21201</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>8/1/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Calvary</u>		24D. LOCATION (City, town, or county) (State) <u>D. D. County, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 30 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Joseph B. Rock</u>		ADDRESS <u>1304 N Central Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		70 7548		REG. NO. 70 7548	
BIRTH NO. 5-326		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) IDA D. STACHOROWSKI (ROSKEY)		2. DATE AND HOUR OF DEATH JULY 28, 1970 10:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME & HOSPITAL BROADWAY & FAIRMOUNT AVE 21231		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 202 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 400 S. ANN ST. 21231			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/14/02	9. AGE (In years last birthday) 67	10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Sebastian Lasek		14. MOTHER'S MAIDEN NAME Regina Krol	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 215-46-9192		17. INFORMANT ADDRESS Miss Rita Roskey, 400 S. Ann Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.014-250.9 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes Mellitus		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: Chronic Hypertension (C) -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one hour many years years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from JULY 28, 1970 to JULY 28, 1970 that (I) (we) last saw the deceased alive on JULY 28, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Patrick F. Dougherty, Jr., M.D.		23B. DATE SIGNED JULY 28, 1970		23C. PHYSICIAN'S NAME (Type) PATRICK F. DOUGHERTY, JR., M.D.	
23D. ADDRESS CHURCH HOME & HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 8/1/70		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus		24D. LOCATION (City, town, or county) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		70 7549	
M-200		70 7549	
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) JOSEPH S. MACH		2. DATE AND HOUR OF DEATH 7/28/70 12:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALT.	
FULL NAME OF HOSPITAL OR INSTITUTION NORTH CHARLES GEN. HOSP		C. CITY OR TOWN BALTIMORE	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 49		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		E. STREET AND NUMBER 1927 GOUGH ST. BALTO MD.	
6. RACE WHITE		8. DATE OF BIRTH 3/7/77	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost birthday) 93	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Processor		11. BIRTHPLACE (State or foreign country) Poland	
10B. KIND OF BUSINESS OR INDUSTRY Humble Oil Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Mach		14. MOTHER'S MAIDEN NAME Mary Giza	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-021095	
17. INFORMANT Bertha Fabiszak		ADDRESS 418 St. Charles St.	
18. 4/23/1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) COLLAPSE OF HEART FAILURE DAYS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC HEART DISEASE		YEARS UNDER 1	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ACCIDENT			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/25 19 70 to 7/28 19 70 that (I) (we) last saw the deceased alive on 7/28 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Gracito V. Patricio		23B. DATE SIGNED 7/28/70	
23C. PHYSICIAN'S NAME (Type) GRACITO V. PATRICIO		23D. ADDRESS KICGH	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/31/70	
24C. NAME OF CEMETERY OR CREMATORY Holy Rosary		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970		25B. NAME OF REGISTRAR Robert E. Bailey MD	
25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS		ADDRESS 1808 EASTERN AVE	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 7550

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ARCHIE LEVINE

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF
HOSPITAL
OR INSTITUTION
(If not in hospital or institution, give street
address or location)

33 JOHNS HOPKINS HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

July 28, 1970

4:47 P.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

B. COUNTY

704

6. SEX

Male

7. RACE

Negro

B. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Aug. 6, 1922

10. AGE (in years
lost birthday)

47

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

811 N. Dallas Street

11. BIRTH PLACE (State or foreign country)

S. Carolina

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

Alfred Levine

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Rosella Vice

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (if yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mary Louise - 811 N. Dallas St.

19.

412.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Fatty metamorphosis of liver

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)22E. INJURY OCCURRED
WHILE AT ☐
WORK NOT WHILE ☐
AT WORK

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/29/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/1/70

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

Monte Carmel, N. Carolina

25A. DATE REC'D BY HEALTH DEPT.

JUL 30 1970

25B. NAME OF REGISTRAR

Robert E. Tabor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Milton E. Clifton - 1129 N. Carolina

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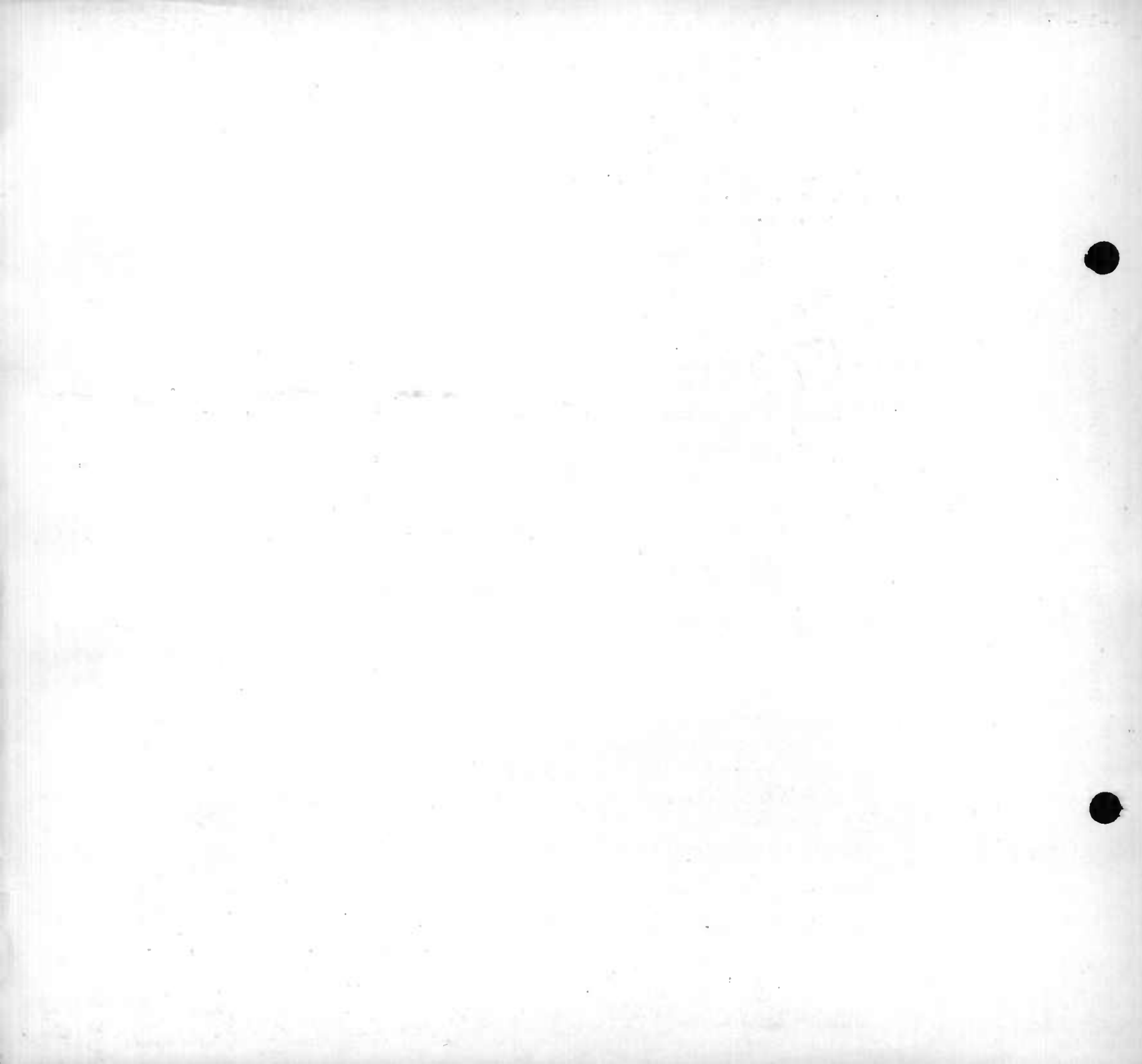
THE UNIVERSITY OF CHICAGO PRESS
CHICAGO, ILL. 60607

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CHICAGO, ILL. 60607

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MURRAY, JOSEPH		7/26/70 9:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
31 Baltimore City Hosp. 4940 Eastern Ave. Baltimore, Md. 21224				Maryland Baltimore 501	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Contractor		?		7-11-14	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
Borsley Pickett		Edie Mae Hill		56	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
Unknown				Georgia	
17. INFORMANT		ADDRESS		12. CITIZEN OF WHAT COUNTRY?	
BCH Records: 4940 Eastern Ave.		Baltimore, Md. 21224		USA	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				5 min.	
ANTECEDENT CAUSES				6 yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				2 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0		NO		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12/20 1968 to 7/26 1970, that (I) (we) last saw the deceased alive on 7/26/70 8:30 PM and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Michael W. Dozen M.D.				7/26/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Michael W. Dozen M.D.				Baltimore City Hosp 4940 Eastern Ave. Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7/23/70		Mt. Calvary Cem.	
25A. DATE REC'D. BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. IF FUNERAL DIRECTOR	
JUL 30 1970		Robert E. Barber, M.D.		Zachary E. Ecker 11297 (burial)	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

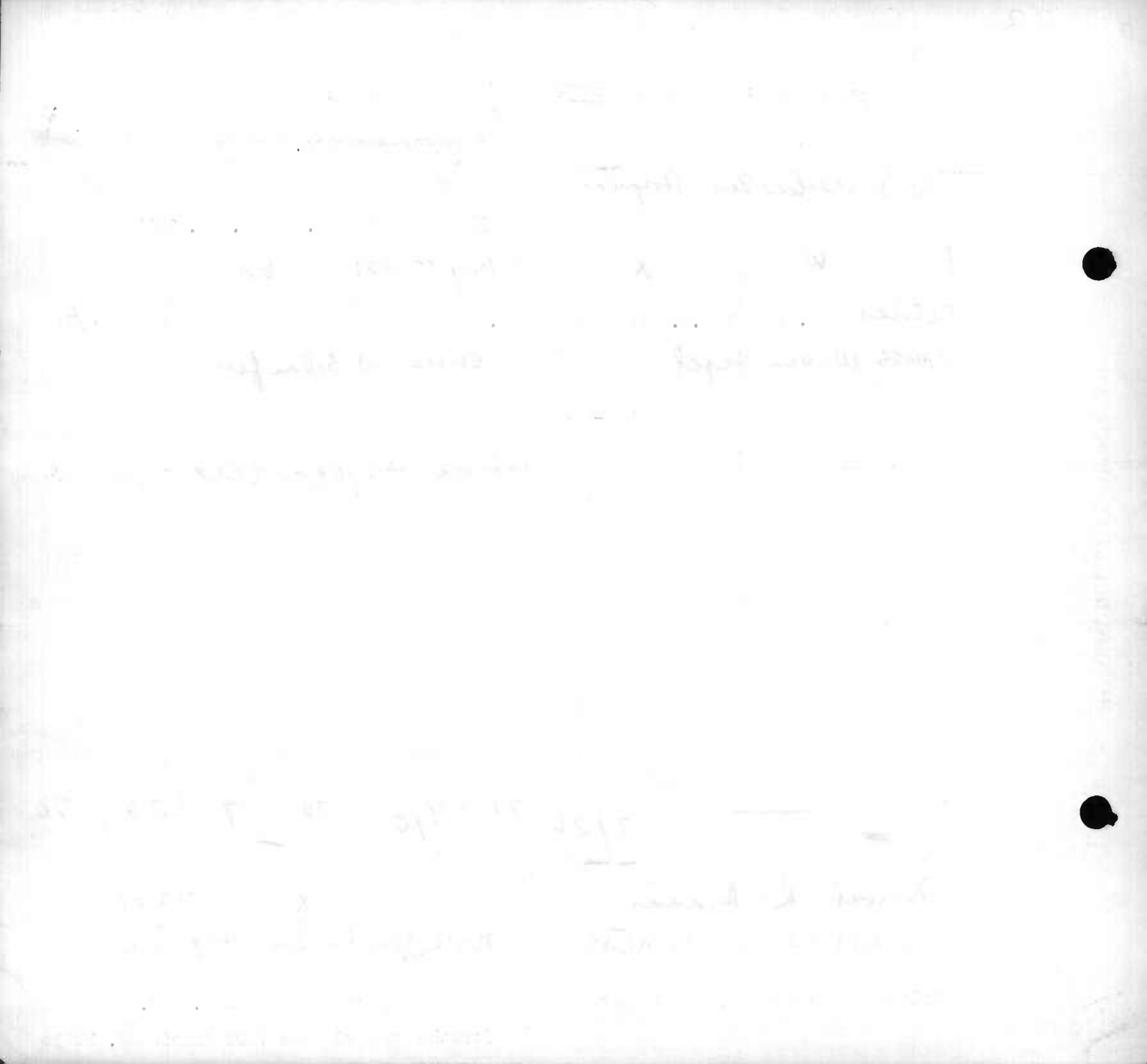
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7552	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) KATHERINE SUSAN MILLER		2. DATE AND HOUR OF DEATH 26 JULY 1970 4:45 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL 43 HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO. C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 31 Honeysuckle Lane.		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-20-05		9. AGE (In years last birthday) 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY HOUSE KEEPING		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME ISRAEL CHEECHAN		
14. MOTHER'S MAIDEN NAME FLORENCE ANDREWS.			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 141-03-8376		17. INFORMANT RUSSELL MILLER 31 HONEYSUCKLE LANE			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). DUODENAL ULCER		19. DATE OF OPERATION 7-20-70		20. CONDITION FOR WHICH OPERATION WAS PERFORMED DUODENAL ULCER	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8:40p 7-9-1970 to 4:45a 7-25-1970 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4:45a 7-25-1970 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE Henry Chen			23B. DATE SIGNED 7-25-70		23C. PHYSICIAN'S NAME (Type) HENRY CHEN MD
23D. ADDRESS 3007 S. Hanover St Balt md 21238			24. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 28 July 70		24C. NAME OF CEMETERY or CREMATORY Hardingville Meth. Church Cem.		24D. LOCATION (City, town, or county) (State) Hardingville New Jersey	
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 7401 Belair Rd. 21236	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

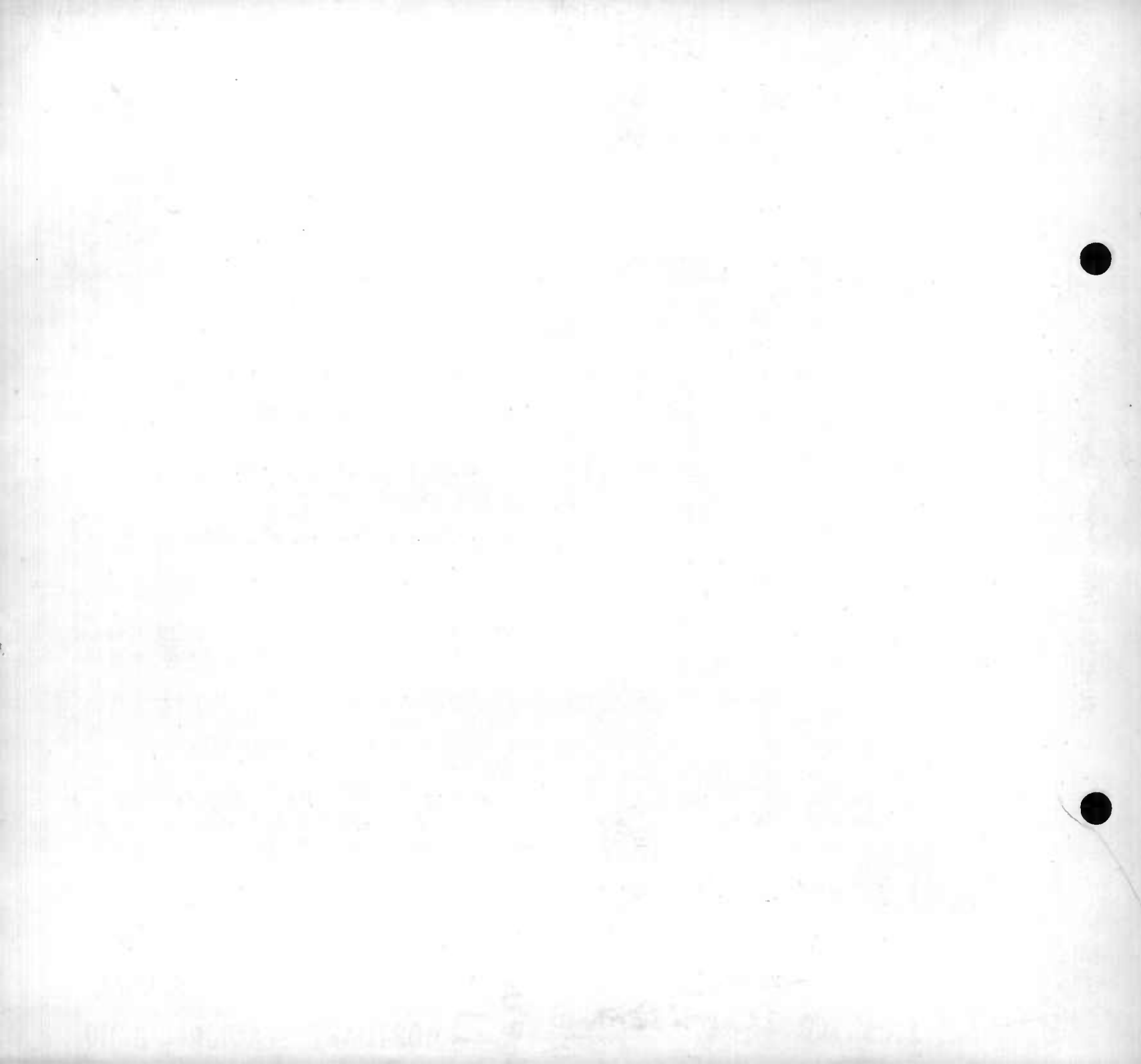
BIRTH NO. 70 7553				BALTIMORE CITY HEALTH DEPARTMENT				X				REG. NO. 70 7553			
1. NAME OF DECEASED (Type or Print) <u>HANCOCK, JULIA, RTH</u>								2. DATE AND HOUR OF DEATH <u>7/26/70</u> <u>6:30 P. M.</u>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>North Charles Gen. Hospital</u>								4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>3416 Glenside Dr. Balto. Md. 21234</u>							
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 22 1907</u>		9. AGE (In years last birthday) <u>63</u>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Caf. worker</u>								10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government Hosp.</u>				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>								13. FATHER'S NAME <u>JAMES W. Van Hagel</u>							
14. MOTHER'S MAIDEN NAME <u>EMMA W. Schaefer</u>								15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>							
16. SOCIAL SECURITY NO. <u>212-20-0178</u>								17. INFORMANT <u>NOG H CHAT</u> ADDRESS							
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).								CAUSE OF DEATH <u>Acute Myocardial Infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:							
19A. DATE OF OPERATION <u>0</u>								19B. CONDITION FOR WHICH OPERATION WAS PERFORMED							
20A. AUTOPSY? (Yes or No) <u>No</u>								20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>								21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)							
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)								21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)							
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>								21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>7/24</u> 19 <u>70</u> to <u>7/26</u> 19 <u>70</u> that (I) (<u>we</u>) last saw the deceased alive on <u>7/26</u> 19 <u>70</u> and that (in my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (did not) view the body after death.															
23A. SIGNATURE <u>Ninevah R. Aranas</u> DEGREE								23B. DATE SIGNED <u>7/26/70</u>							
23C. PHYSICIAN'S NAME (Type) <u>NINEVAH R. ARANAS</u> DEGREE								23D. ADDRESS <u>North Charles Gen. Hospital</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>								24B. DATE <u>July 29, 70</u>							
24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>								24D. LOCATION (City, town, or county) (State) <u>Parkville Balto. Md.</u>							
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 30 1970</u>								25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>							
25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>								ADDRESS <u>7401 Belair Rd. 21236</u>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7554	
<div style="display: flex; justify-content: space-between;"> S-536 70 7554 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) MARY SAUNDERS			2. DATE AND HOUR OF DEATH 7-25-70 7 ⁴⁵/_A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BOLTON HILL NURSING HOME			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 646 W. DOVER ST.		21-01
5. SEX 4	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/7	9. AGE (In years, lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-03-2632		17. INFORMANT ADDRESS Bolton Hill Nursing Home - 1400 JOHN ST.	
18. 412.41 x 093.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Lung Cancer			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA, (C) middle cerebral artery (B) Arteriosclerotic Cardiovascular Disease (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH March 2, 1970 Years Years
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from March 27 19 70 to July 25 19 70 , that (I) (we) last saw the deceased alive on July 25 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Peter H. Rheinstein, MD			23B. DATE SIGNED July 26, 1970		23C. PHYSICIAN'S NAME (Type) PETER H. RHEINSTEIN, MD
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE 7-29-70		24C. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS MEDICAL SCHOOL
25A. DATE REC'D BY HEALTH DEPT. JUL 30 1970			25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD



H-220 70 7555

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

70 7555

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CLARENCE HUGHES		2. DATE AND HOUR OF DEATH 29 July 1970 12 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1028 S. STREEPER ST.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
1940 Eastern Avenue Baltimore, Maryland 21224		E. STREET AND NUMBER		21224	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-02	9. AGE (In years lost birthday) 67	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Dye Clerk		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West VIRGINIA	
12. FATHER'S NAME FRANK HUGHES		13. MOTHER'S MAIDEN NAME LADOSCA ROSE		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 235-18-6578		17. INFORMANT 4940 Eastern Avenue Baltimore, Maryland 21224 BCH: Records	
18. 710.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic Cardiovascular Dis DUE TO, OR AS A CONSEQUENCE OF: (C) Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 70 min	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Chronic Obstructive Pulmonary Dis.			
19A. DATE OF OPERATION 28 July 1970		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Temp Stemaker Insertion		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 26 July 1970 to 29 July 1970 and that (2) (we) last saw the deceased alive on 29 July 1970 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert H. Creech, M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 29 July 1970	
23C. PHYSICIAN'S NAME (Type) Robert H. Creech M.D.		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8/1/70	24C. NAME OF CEMETERY or CREMATORY ST. STANISLAUS		24D. LOCATION (City, town, or county) (State) DUNDALK MD	
25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR JOHN WEBER & SONS ADDRESS 401 S CHESTER ST	

FUNERAL DIRECTOR: IMPORTANT

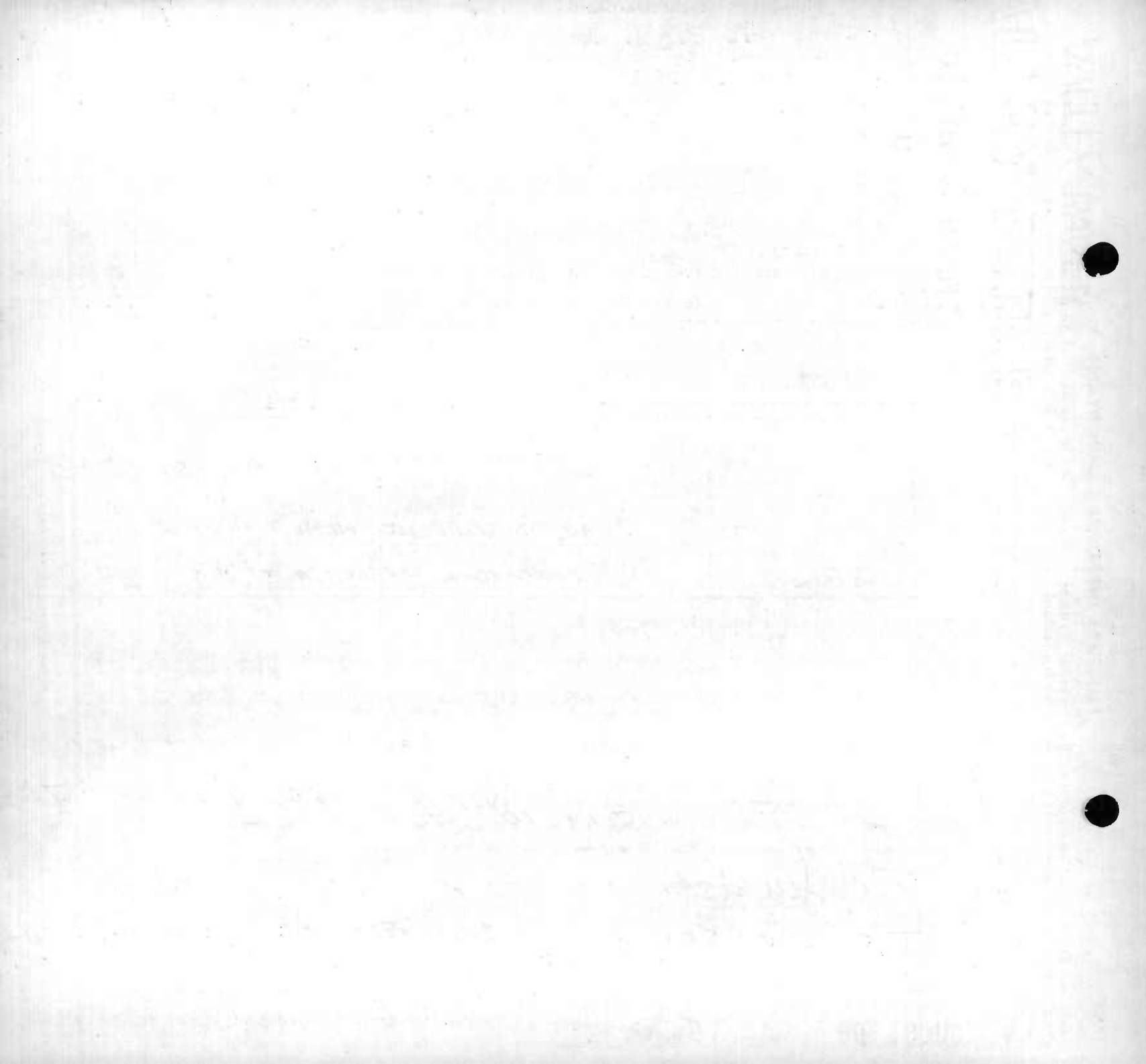
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 7556		70 7556	
F-663		70 7556		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) WILLIS K. FREIERT				2. DATE AND HOUR OF DEATH July 24, 1970			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Towson D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 515 St. Francis Road			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov, 18, 1914		9. AGE (In years last birthday) 55 Years	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director of Sales		10B. KIND OF BUSINESS OR INDUSTRY Television		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William K. Friert				14. MOTHER'S MAIDEN NAME Helen M. Young			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-18-5774		17. INFORMANT Mrs. Rose Mary V. Friert, Same as # 4			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH CORONARY ARTERY OCCLUSION IMMEDIATE ARTERIOSCLEROTIC HEART DISEASE MYOCARDIAL INFARCTION - 10/68				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from NOV 18 1968 to JULY 24 1970 , that (I) (we) last saw the deceased alive on JULY 10 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.							
23A. SIGNATURE T. C. Siwinski				23B. DATE SIGNED 7/27/70			
23C. PHYSICIAN'S NAME (Type) T. C. SIWINSKI				23D. ADDRESS 206 W. PENNA. AV. TOWSON MD 21204			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-28-70		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Memorial		24D. LOCATION (City, town, or county) (State) Cockeysville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

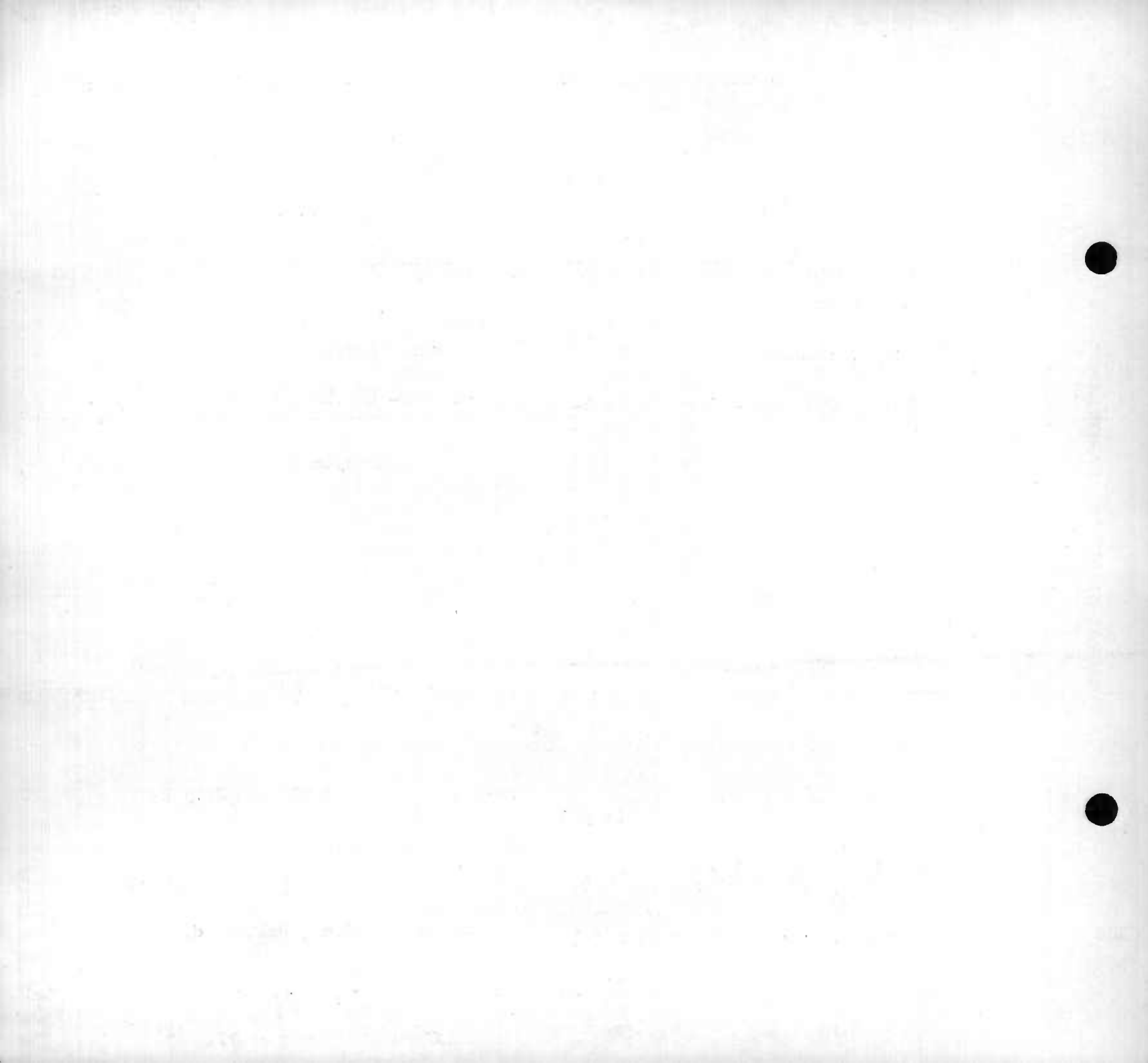
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7557	
CERTIFICATE OF DEATH					
BIRTH NO. H-652 70 7557					
1. NAME OF DECEASED (Type or Print) <u>EDNA C. HERING</u>			2. DATE AND HOUR OF DEATH <u>7/25/70</u> <u>9.15 A.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>85. WOODINGTON RD.</u> <u>21229</u>			A. STATE <u>MD</u>		B. COUNTY <u>28-64</u>
			C. CITY OR TOWN <u>BALTO.</u>		
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			E. STREET AND NUMBER <u>85. WOODINGTON RD.</u>		
5. SEX <u>7</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/5/05</u>	9. AGE (In years last birthday) <u>65</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESLADY</u>
11. BIRTHPLACE (State or foreign country) <u>MD</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		
13. FATHER'S NAME <u>CHARLES DAVIS</u>			14. MOTHER'S MAIDEN NAME <u>CORA MCCREA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>F. J. HERING</u>
18. <u>174X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of the breast with metastases</u>			CAUSE OF DEATH <u>Carcinoma of the breast with metastases</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>7-25-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 4</u> 19 <u>56</u> to <u>July 25</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>7-25-70</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John A. Nesbitt, Jr., M.D.</u>				23B. DATE SIGNED <u>7-27-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>John A. Nesbitt, Jr., M.D.</u>				23D. ADDRESS <u>1009 Frederick Road</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/28/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S</u>	
24D. LOCATION (City, town, or county) (State) <u>ELLICOTT CITY, MD.</u>					
25A. DATE RECD BY HEALTH DEPT. <u>JUL 31 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Talbot, M.D.</u>		25C. FUNERAL DIRECTOR <u>E. S. MACNABER</u>	
25D. ADDRESS <u>27228</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7558	
S-353 70 7558		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Herbert Marshall Stanton		2. DATE AND HOUR OF DEATH July 29, 1970 11:30 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Parkway		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Pa. B. COUNTY ✓-35- C. CITY OR TOWN Merion D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 221 Meeting House Lane	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/17/23
9. AGE (in years lost birthday) 46		If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wholesaler		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alex F. Stanton		14. MOTHER'S MAIDEN NAME Fannie Spoont	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USA 1941-1945		16. SOCIAL SECURITY NO. 197-16-0270	
17. INFORMANT Records- US PHS Hospital, Balto, Md.		ADDRESS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Astrocytoma DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 7 19 70 to July 29 19 70 , that (I) (we) last saw the deceased alive on July 29 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Gary E. Feldman, M.D.		23B. DATE SIGNED 7/30/70	
23C. PHYSICIAN'S NAME (Type) Gary E. Feldman, SA Surgeon (R)		23D. ADDRESS US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/31/70	
24C. NAME of CEMETERY or CREMATORY MT Shamon		24D. LOCATION (City, town, or county) Springfield Pa	
25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970		25B. NAME OF REGISTRAR Robert E. Faber, M.D.	
25C. FUNERAL DIRECTOR Gylen Lewis & Sons		25D. ADDRESS 9610 Restoration Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 70 7559	
BIRTH NO. 5430 70 7559		CERTIFICATE OF DEATH		27-July-70 5:40 P.M.	
1. NAME OF DECEASED (Type or Print) Lydia G Scaletti		2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore Gen. Hosp.		A. STATE Md.		B. COUNTY 25-34	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3528 7th St, 21225			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-19-04	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME August Unknown 214 62 1037		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? US 18	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 589-888-5531		17. INFORMANT Husband - Leo Scaletti - Same ADDRESS	
18. 4-10-9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <2 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ASCVD DUE TO, OR AS A CONSEQUENCE OF:		Years	
		(C) CHF		>6 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Obesity			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 26-July 1970 to 27-July 1970 that (I) (we) last saw the deceased alive on 27-July 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard E Fisher MD DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Richard E Fisher MD DEGREE		23D. ADDRESS South Baltimore Gen Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/30/70		24C. NAME of CEMETERY or CREMATORY Meadowridge Memorial Pk. ElkrIDGE, Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hwy. Baltimore, Md. 21285	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7560

BIRTH NO.

1. NAME OF DECEASED (Type or Print) URSULA F. FLAMBURIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 101 E. Mount Royal Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour July 29, 1970 2:55 P M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 12-22-1912		10. AGE (In years last birthday) 57 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator		14B. KIND OF BUSINESS OR INDUSTRY C. & P. Telephone Co.	
15. MOTHER'S MAIDEN NAME Ursula Watson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 212-05-1638		18. INFORMANT ADDRESS Mr. David R. Karper, 1713 DeSota Road 21230	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 30, 1970			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-3-1970	
24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

DEED

Know all men that I, the undersigned, for and in consideration of the sum of \$100.00 to me in hand paid by the said

JOHN A. DAVIS, the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said

JOHN A. DAVIS, his heirs and assigns forever, all that certain

tract of land in the County of Dallas, State of Texas, containing

one (1) acre, more or less, the corners of which are

marked by

iron pins

as shown on

the plat

recorded in

the office of the

County Clerk of

Dallas County,

Texas, as the same

appears on

plat

number

one (1)

in the

book of

plats

of Dallas

County,

Texas.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7561

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN J. BLUDIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour July 27, 1970 4:33 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 11-2-06		10. AGE (in years lost birthday) 63	
11. BIRTHPLACE (State or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John J. Bludis		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR	
15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII-2	
17. SOCIAL SECURITY NO. 201-01-8375		18. INFORMANT SON	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hanging (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1600 McHenry Street 19-03	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 7-27-70 3:15 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Subject hanged himself		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/28/70	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-30-70	
24C. NAME OF CEMETERY or CREMATORY London Natl		24D. LOCATION (City, town, or county) (State) Baltimore - md	
25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR WALTERS-FUNERAL HOME		25D. ADDRESS PRATT & STRICKER ST	

11-2-00

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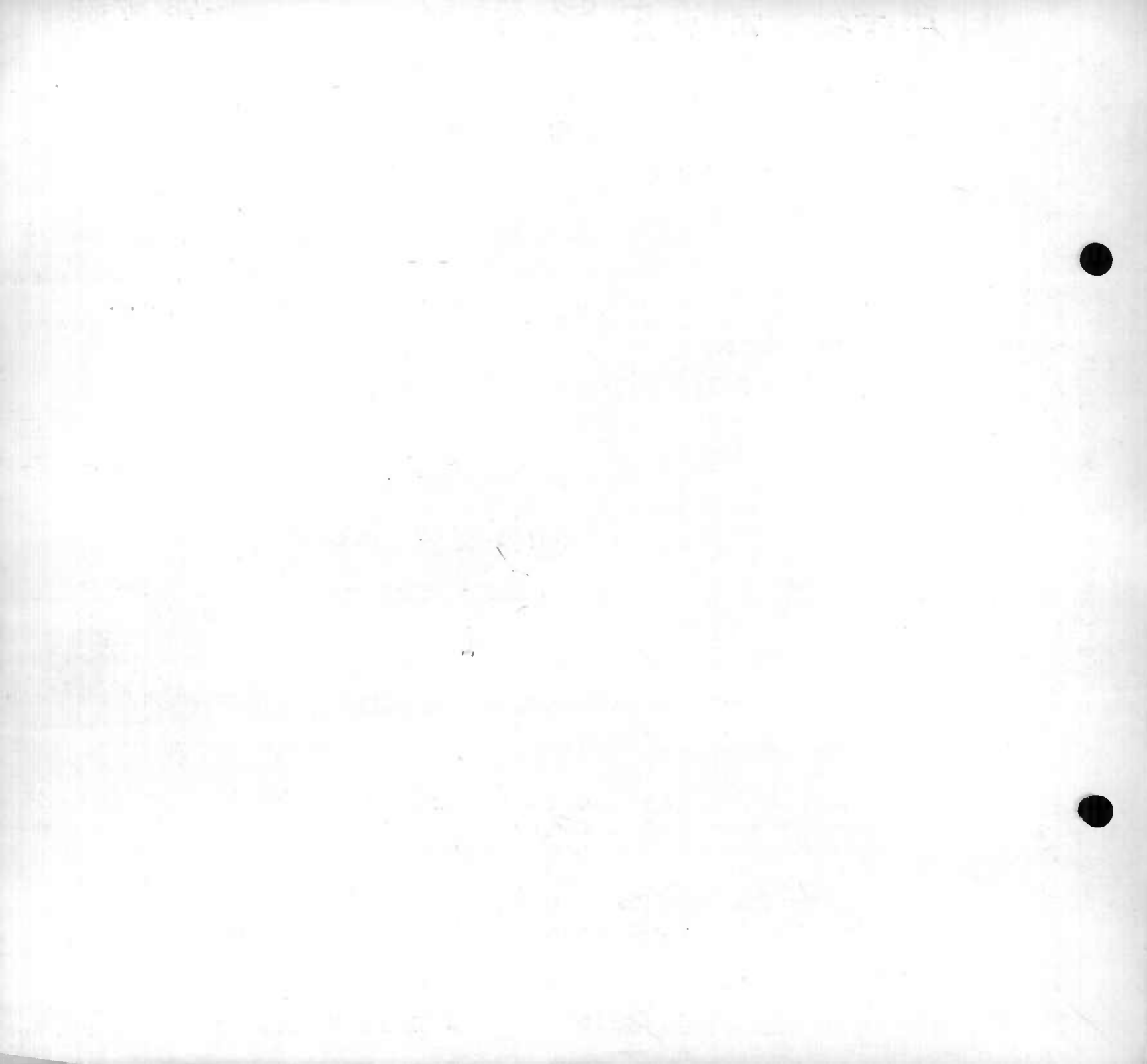
11-2-00

11-2-00

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

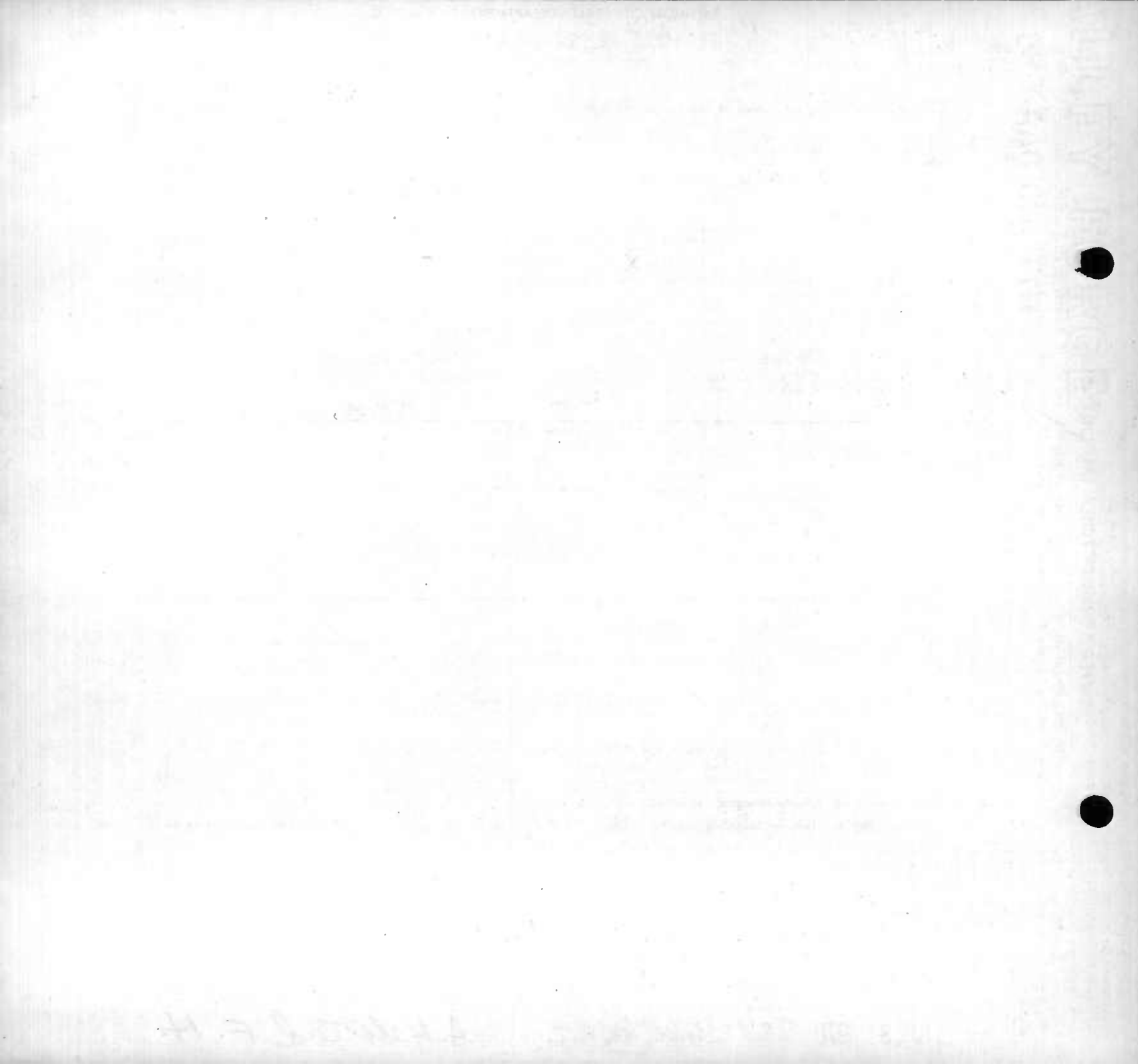
BALTIMORE CITY HEALTH DEPARTMENT				70 7562		70 7562	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) JESS ANDERSON				2. DATE AND HOUR OF DEATH 7-19-70 12:15Pm. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BOLTON HILL NURSING CENTER				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
5. SEX MALE				6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND	
13. FATHER'S NAME CHRISOPHER ANDERSON				14. MOTHER'S MAIDEN NAME MINNIE BEARD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADMISSION RECORD ADDRESS	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pglt Perforation (B) Diabetes mellitus DUE TO, OR AS A CONSEQUENCE OF: (C) Schizophrenia, Acute		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5/22/70 years years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/30 19 70 to 7/19 19 70 , that (I) (we) last saw the deceased alive on 7/19 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Alan H. Maentz				Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/20/70	
23C. PHYSICIAN'S NAME (Type) ALAN H. MAENTZ MD				23D. ADDRESS 2 E Red St Bldg 4122			
24A. BURIAL CREMATION, (Specify)		24B. DATE 7/25/70		24C. NAME OF CEMETERY or CREMATORY MT Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Bxa A County Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 7563
BIRTH NO. A-352 70 7563				
1. NAME OF DECEASED (Type or Print) ADAMS, JAMES		2. DATE AND HOUR OF DEATH July 29, 1970 1 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Melchor Nursing Home		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 2327 N. Charles St. 12-06		
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-2-97	9. AGE (In years last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10B. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Unknown
12. CITIZEN OF WHAT COUNTRY? United States				
13. FATHER'S NAME James Adams		14. MOTHER'S MAIDEN NAME Fannie Baxter		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 579-14-2363		17. INFORMANT Chart,
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Vascular Accident (B) DUE TO, OR AS A CONSEQUENCE OF: Generalized Arteriosclerosis (C)		
		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 3 days several years		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from May 19 69 to July 19 70 , that (I) (we) last saw the deceased alive on July 28 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE M. Zimmerman				23B. DATE SIGNED 7/29/70
23C. PHYSICIAN'S NAME (Type) Log M. Zimmerman MD		23D. ADDRESS 3202 Harford Rd. Baltimore Md		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/4/70	24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery	24D. LOCATION (City, town, or county) (State) A A County M	
25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970	25B. NAME OF REGISTRAR Robert E. Farber, Jr.	25C. FUNERAL DIRECTOR A. Halstead F. H.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-363		70 7564		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7564	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Edwards, Calvin</u>				2. DATE AND HOUR OF DEATH <u>7-29-70</u> <u>9:15</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Provident Hospital</u> <u>1514 Divison Street</u> <u>Baltimore, Maryland 21217</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>				6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>01-18-33</u>				9. AGE (in years last birthday) <u>37</u>		10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>James edwards</u>			
14. MOTHER'S MAIDEN NAME <u>Ethel Webb</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>01-320</u>			
16. SOCIAL SECURITY NO. <u>212-30-9264</u>				17. INFORMANT <u>Mrs. Ethel Edwards-Mother</u> 1526 Mountmor Ct.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Hepatic Coma, Cirrhosis, Laennec</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days 3 years</u>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Alcoholic Cirrhosis</u>				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Laennec Cirrhosis</u> (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>7-26-70</u> to <u>7-29-70</u> that (I) (we) last saw the deceased alive on <u>7-29-70</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Veniedo A. Alidio, M.D.</u>				23B. DATE SIGNED <u>July 30, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>VENIEDO A. ALIDIO M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/4/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt Auburn Cemetry</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 31 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halst</u>		ADDRESS <u>ead 1206 W North Ave</u>	



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7565

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MABLE MATTHEWS

2. DATE OF DEATH

Known ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

213 S. Spring Ct.

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Md.

B. COUNTY

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

C. CITY OR TOWN

Balto. m

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

9. DATE OF BIRTH

???????

10. AGE (In years last birthday)

68

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U S A

E. STREET AND NUMBER

213 S. Spring Ct.

13. FATHER'S NAME

Unknown

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

Mrs Williams

ADDRESS

19.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Hypertensive & arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Nephritis, overweight

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion

resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-24-70

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

7/30/70

24C. NAME OF CEMETERY or CREMATORY

MT. CAL. CEM.

24D. LOCATION (City, town, or county)

ANNE ARUNDEL COUNTY

25A. DATE REC'D BY HEALTH DEPT.

JUL 31 1970

25B. NAME OF REGISTRAR

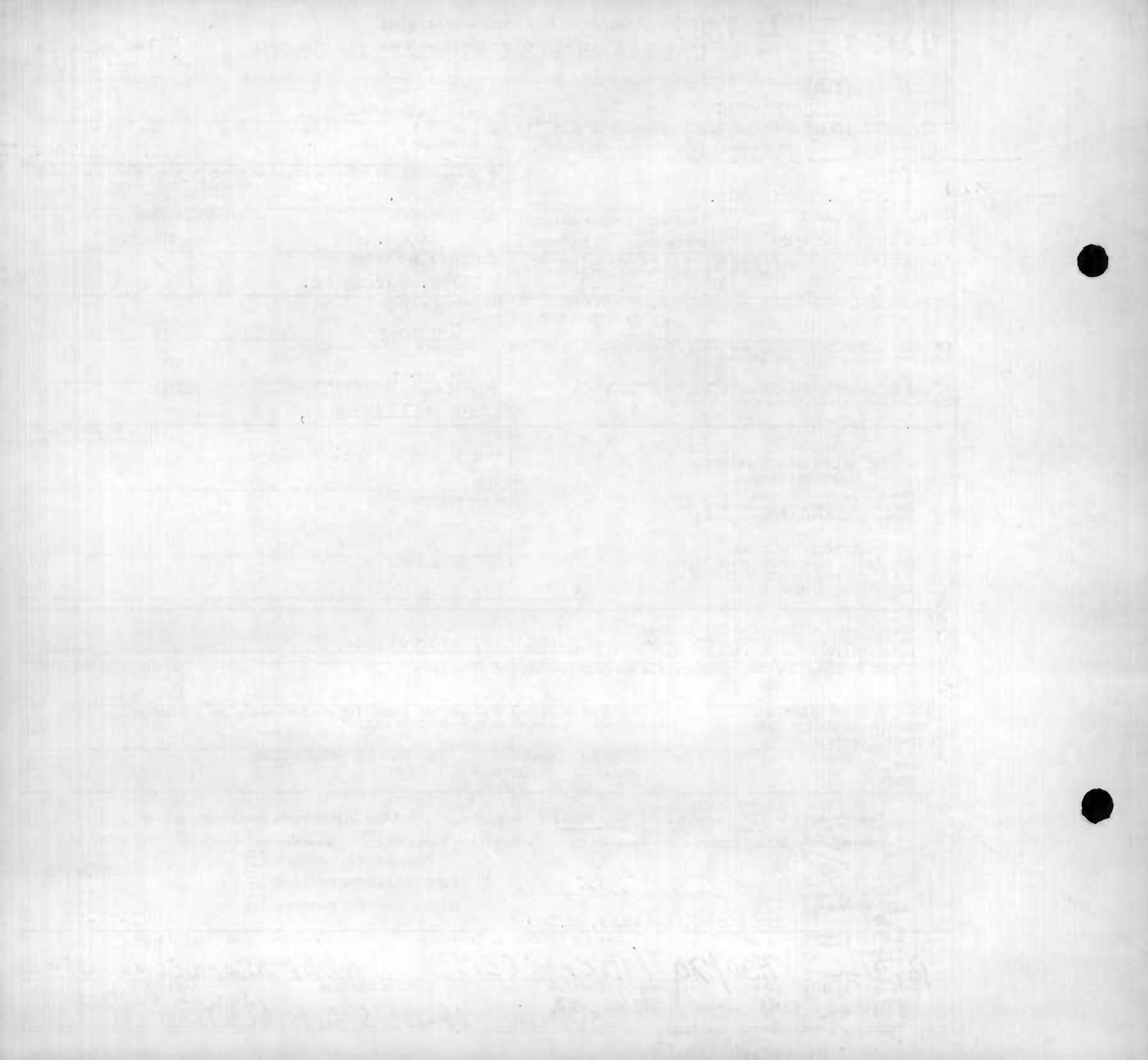
Robert E. Taber, M.D.

25C. FUNERAL DIRECTOR

ADOLPHUS A. HALSTEAD

ADDRESS

1206 W. NORTH AVE.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7566	
CERTIFICATE OF DEATH					
BIRTH NO. 70 7566		1. NAME OF DECEASED (Type or Print) <u>Charles Kelly</u>			
2. DATE AND HOUR OF DEATH <u>7/26/70 3:45 PM</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The University of Maryland Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>601 PIERCE ST</u>		F. STREET AND NUMBER <u>17-01</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/05/00</u>	9. AGE (In years last birthday) <u>69</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>not known</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>not known</u>		14. MOTHER'S MAIDEN NAME <u>???????</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-09-9188</u>		17. INFORMANT <u>Chart,</u> ADDRESS	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Presumed Carcinoma of sigmoid colon</u>			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 26</u> 19 <u>70</u> to <u>July 26</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>July 26</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Davis M.D.</u>		23B. DATE SIGNED <u>July 26 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Davis</u>	
23D. ADDRESS		23E. DEGREE		23F. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/1/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cemetery</u>	
24D. LOCATION (City, town, or county) <u>A A County Md</u>		24E. LOCATION (City, town, or county) <u>A A County Md</u>		24F. LOCATION (City, town, or county) <u>A A County Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 31 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead 1206 W North Ave</u>	



70 7567

BALTIMORE CITY HEALTH DEPARTMENT

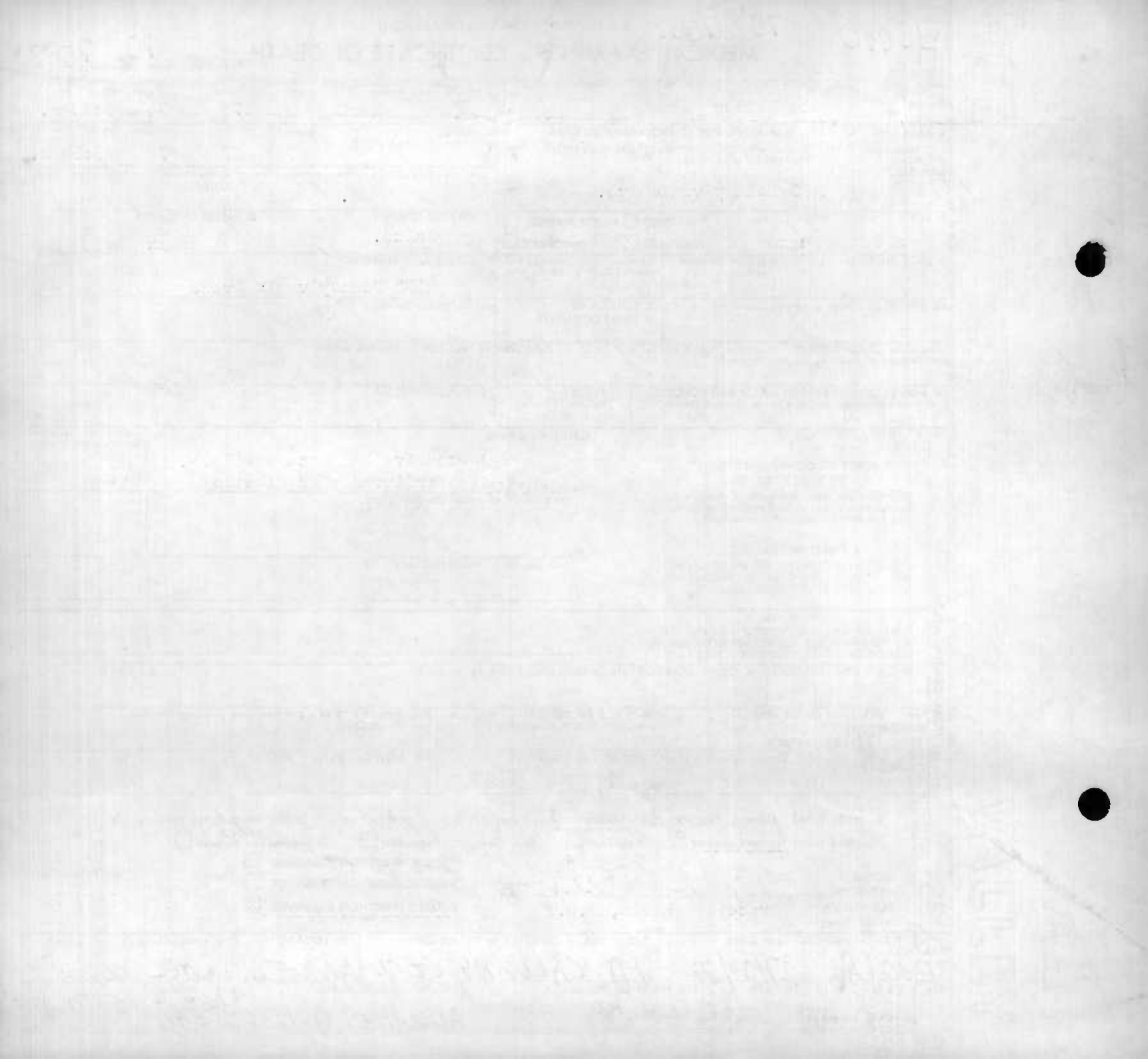
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 7567

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Abe Holley		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month 7 Day 27 Year 70 Hour 5:50 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2133 Pennsylvania Ave.		3. DATE PRONOUNCED DEAD Month 7 Day 27 Year 70 Hour 5:50 a.m.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 65		E. STREET AND NUMBER 2133 Pennsylvania Avenue 14-03	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Hypertensive and Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 7/27/70		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	
24B. DATE 7/30/70		24C. NAME of CEMETERY or CREMATORY MT. CALVARY CEM.	
24D. LOCATION (City, town, or county) (State) ANNE ARUNDEL COUNTY		25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970	
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS ADOLPHUS A. HALSTEAD 1206 W. NORTH AVE	



BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

LLOYD LOUDEN

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BON SECOURS HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

July 28, 1970

10:34 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

5/28/52

10. AGE (In years
last birthday)

18

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1849 W. Mulberry Street

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
U.S. WHAT COUNTRY?

13. FATHER'S NAME

????????

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Eunice Louden

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

217-58-2161

18. INFORMANT

ADDRESS

Miss Eunice Louden, 2003 W Lexington St

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Narcotics addiction

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/29/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/1/70

24C. NAME of CEMETERY or CREMATORY

M. Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore MD

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 31 1970

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

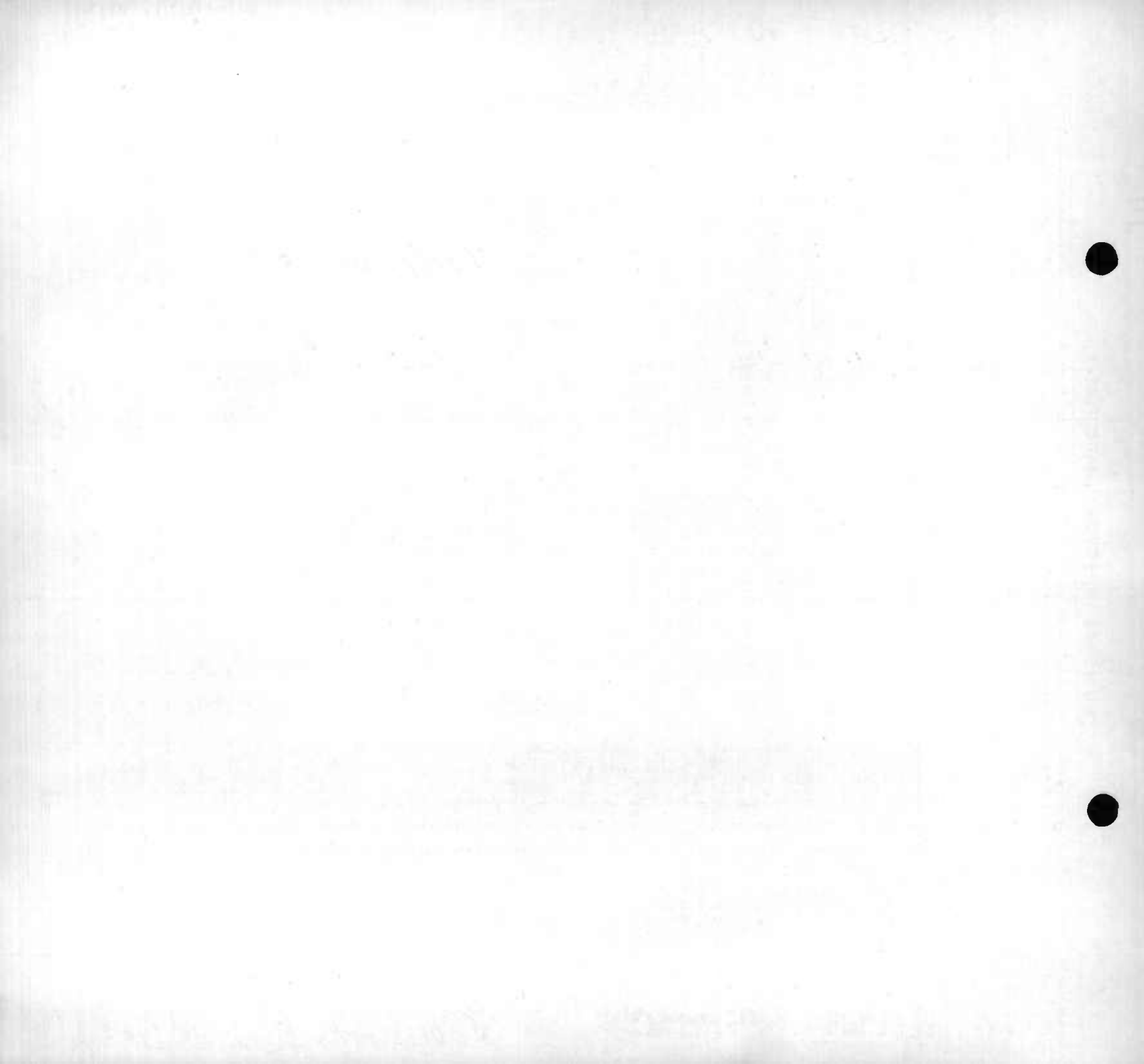
ADDRESS

no:

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7569	
1. NAME OF DECEASED (Type or Print) Ella Johnson		2. DATE AND HOUR OF DEATH 7-28-70 7:00 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1811 Madison Ave Baltimore, Md. 21217		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1811 Madison Ave 19-03			
5. SEX Female	6. RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/1889	9. AGE (In years lost birthday) 81	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Henry Garrison		14. MOTHER'S MAIDEN NAME Helen Randall		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Richard W. Hoels 1811 Madison Ave	
18. 157.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Pancreas		6 mos	
		(B) Arterio Sclerotic Heart Disease		1 yr	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-28-1970 to 7-28-1970, that (I) (we) last saw the deceased alive on 7-28-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. Franklin Phillips M.D.		23B. DATE SIGNED 7/31/70		23C. PHYSICIAN'S NAME (Type) G. Franklin Phillips M.D.	
23D. ADDRESS 558 McMechen St Balto Md.		23E. FUNERAL DIRECTOR V. Brooks Ruggold 1463 N. Cary St			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial Aug 1/70 Mt. Calvary		24B. DATE		24C. NAME OF CEMETERY or CREMATORY Baltimore Md.	
24D. LOCATION		24E. (City, town, or county) (State)			
25A. DATE RECD BY HEALTH DEPT. JUL 31 1970		25B. NAME OF REGISTRAR		25C. ADDRESS	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 7570

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WENDELL HALL		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour July 30, 1970 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour July 30, 1970 5:29 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 6/7/41		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 29		E. STREET AND NUMBER 1516 E. Hoffman Street 8-07	
11. BIRTHPLACE (State or foreign country) Balto, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Hall		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic	
15. MOTHER'S MAIDEN NAME Winnie Walker		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) YES 12/13/61-11/11/63	
17. SOCIAL SECURITY NO. 217-38-3532		18. INFORMANT Margie Hall	
19. CAUSE OF DEATH 070X I		ADDRESS 1516 E. Hoffman St.	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Massive hepatic necrosis		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Probable viral hepatitis in drug addict		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 30, 1970			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/3/70	
24C. NAME OF CEMETERY or CREMATORY Balto National		24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave	
25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Joseph G. Lock		ADDRESS 504 N. Central Ave	

Letter from M.E.'s office

9-2-70

M.H.

FUNERAL DIRECTOR: IMPORTANT

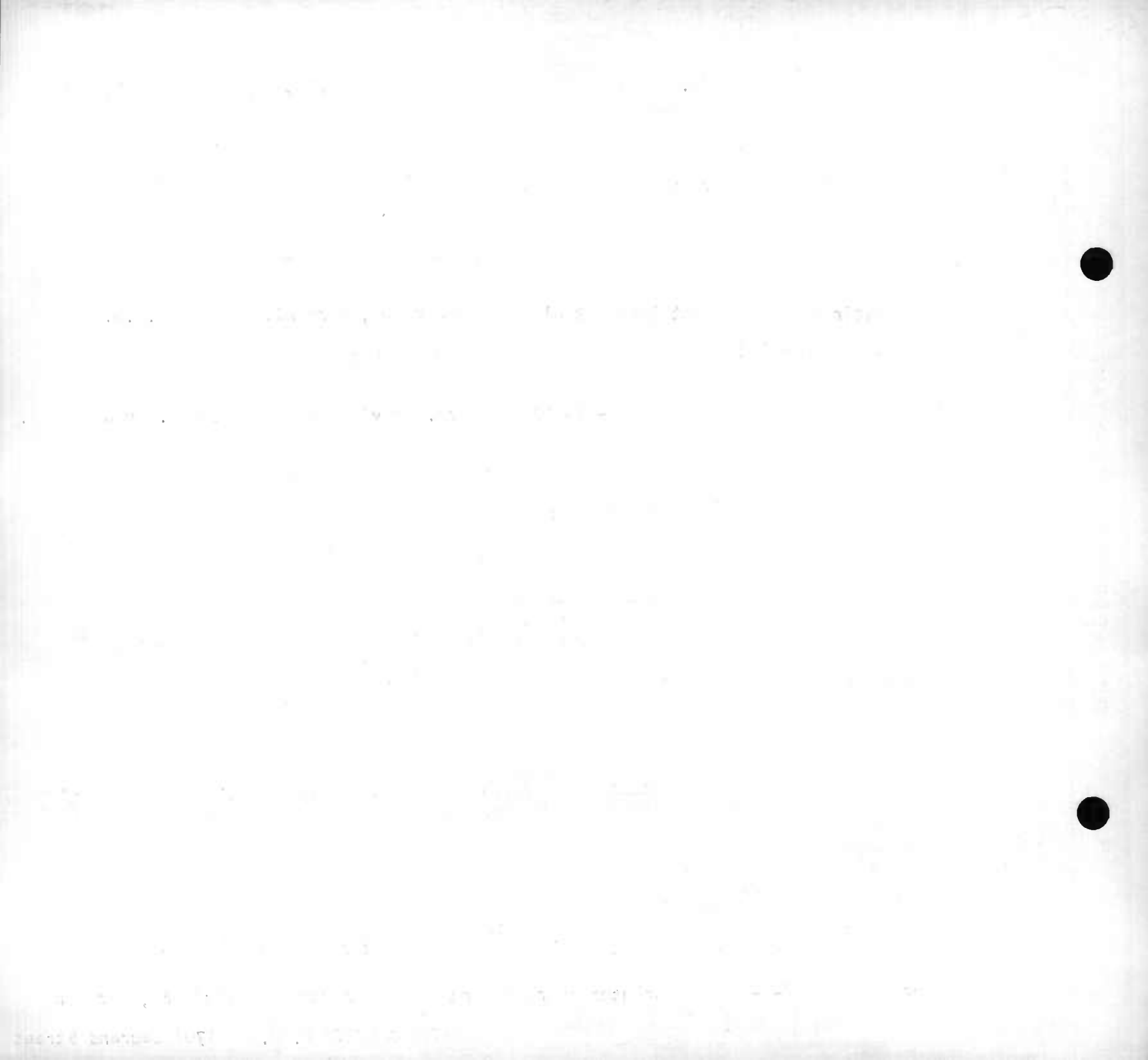
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

X-145		70 7571		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7571	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) KOBYLINSKI KAROL		2. DATE AND HOUR OF DEATH 7.26.1970 8.00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home & Hospital 100 N Broadway Balt 212		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2.07.04	
9. AGE (In years last birthday) 66 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10B. KIND OF BUSINESS OR INDUSTRY RET.		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? American		13. FATHER'S NAME Karol Kobylinski		14. MOTHER'S MAIDEN NAME Catherine Chagnacke			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218 091712		17. INFORMANT Jan Kobylinski wife		ADDRESS 2621 Fleet St. (24)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.91				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Auto m. i. - Pulmonary edema		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: ASH & ch. ob. disease - yrs.			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) 1 (Year) 1 (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 7.26 19 70 to 7.26 19 70 that (1) (we) lost saw the deceased alive on 7.26 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Abdus Samad MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7.26.70	
23C. PHYSICIAN'S NAME (Type) ABDUS SAMAD		23D. ADDRESS MD. Church Home & Hospital Baltimore MD. 21231					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7/30/70		24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI		ADDRESS 2525 FLEET ST	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 7572	
BIRTH NO. 370 7572		1. NAME OF DECEASED (Type or Print) HENRY W. BELT		2. DATE AND HOUR OF DEATH 7/29/70 8 30 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1116 N. MILTON AVENUE 08-53		
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-4-00	9. AGE (In years last birthday) 70	10. Under 1 Yr. Months Days Hours Min. 11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Cumberland, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME NAPOLEON BELT		
14. MOTHER'S MAIDEN NAME Julia Belt			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 213-07-7379		17. INFORMANT Mrs. Sylvia Thomas ADDRESS 693 S. Avondale Rd.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 1621 I			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral metastasis (B) Pulmonary Carcinoma (C) _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ASCVD		
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from 7/26 19 70 to 7/29 19 70 and that (I) (we) last saw the deceased alive on 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Douglas A. Greene			23B. DATE SIGNED 7/29/70		23C. PHYSICIAN'S NAME (Type) Douglas Greene MD
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 8-1-70		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park
24D. LOCATION Arbutus Baltimore, Maryland			25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970		
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			25C. FUNERAL DIRECTOR MORTON & DYETT F. H. ADDRESS 1701 Laurens Street		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 7573		BALTIMORE CITY HEALTH DEPARTMENT		70 7573	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) King, Frank			2. DATE AND HOUR OF DEATH 7-28-70 8:40 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital 1514 Divison Street Baltimore, Maryland 21217			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male			6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			10B. KIND OF BUSINESS OR INDUSTRY Steel Worker		8. DATE OF BIRTH 4-26-05
13. FATHER'S NAME Bray King			14. MOTHER'S MAIDEN NAME Carrie King		9. AGE (In years lost birthday) 65 11. Under 1 Yr. Months: Days: 12. Under 24 Hrs. Hours: Min.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-10-3799		11. BIRTHPLACE (State or foreign country) N. C.
17. INFORMANT Mr. Donald King-Son			ADDRESS 3754 Columbus Dr.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinomatosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (I) stating the UNDERLYING CONDITION last Benign Prostatic Hyperplasia II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Arteriosclerotic Heart Disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 wk Unknown 3 yrs		
19A. DATE OF OPERATION 7-28-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-06-70 19 to 7-28-70 19 that (I) (we) last saw the deceased alive on 7-28-70 19 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Roland T. Smoot, M.D. DEGREE				23B. DATE SIGNED July 28, 1970	
23C. PHYSICIAN'S NAME (Type) ROLAND T. SMOOT M.D. DEGREE				23D. ADDRESS 1514 Divison Street Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-1-70		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970			
25B. NAME OF REGISTRAR Robert E. Smith, M.D.		25C. FUNERAL DIRECTOR MORTON & DYETT F. H.			
25D. ADDRESS 1701 Laurens Street					



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

<p>1. NAME OF DECEASED (Type or Print) Claudette Walker</p>		<p>2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> Month 7 Day 25 Year 1970 Hour M.</p>				
<p>4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 312 E. Lafayette Ave.</p>		<p>3. DATE PRONOUNCED DEAD Month 7 Day 25 Year 1970 Hour 12:45 AM M.</p>				
<p>6. SEX F.</p>		<p>7. RACE C</p>		<p>8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		
<p>9. DATE OF BIRTH 10-14-42</p>		<p>10. AGE (In years lost birthday) 25 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.</p>		<p>5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY</p>		
<p>11. BIRTHPLACE (State or foreign country) Baltimore</p>		<p>12. CITIZEN OF WHAT COUNTRY?</p>		<p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>		
<p>14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown</p>		<p>14B. KIND OF BUSINESS OR INDUSTRY</p>		<p>E. STREET AND NUMBER 312 E. Lafayette Ave. 12-03</p>		
<p>16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>17. SOCIAL SECURITY NO.</p>		<p>13. FATHER'S NAME Steven H Johnson 15. MOTHER'S MAIDEN NAME Fuzzie Moore 18. INFORMANT Fuzzie Johnson ADDRESS</p>		
<p>19. 304.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Narcotic addiction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>						<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>
<p>20A. DATE OF OPERATION</p>		<p>20B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>				<p>21. AUTOPSY? (Yes or No) yes</p>
<p>22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?</p>		
<p>22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>22F. HOW DID INJURY OCCUR?</p>		
<p>23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER Deputy Chief Medical Examiner</p>						
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 7-30-70</p>		<p>24C. NAME of CEMETERY or CREMATORY Calvary Cem</p>		<p>24D. LOCATION (City, town, or county) (State) C.D. Co. Md</p>
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970</p>		<p>25B. NAME OF REGISTRAR Robert E. Fisher, M.D.</p>		<p>25C. FUNERAL DIRECTOR Raymond Sanders ADDRESS 2176 Preeton</p>		

11/11/70 - Letter from M.E.O.

Apc.

ACADEMY BOND

50% COTTON

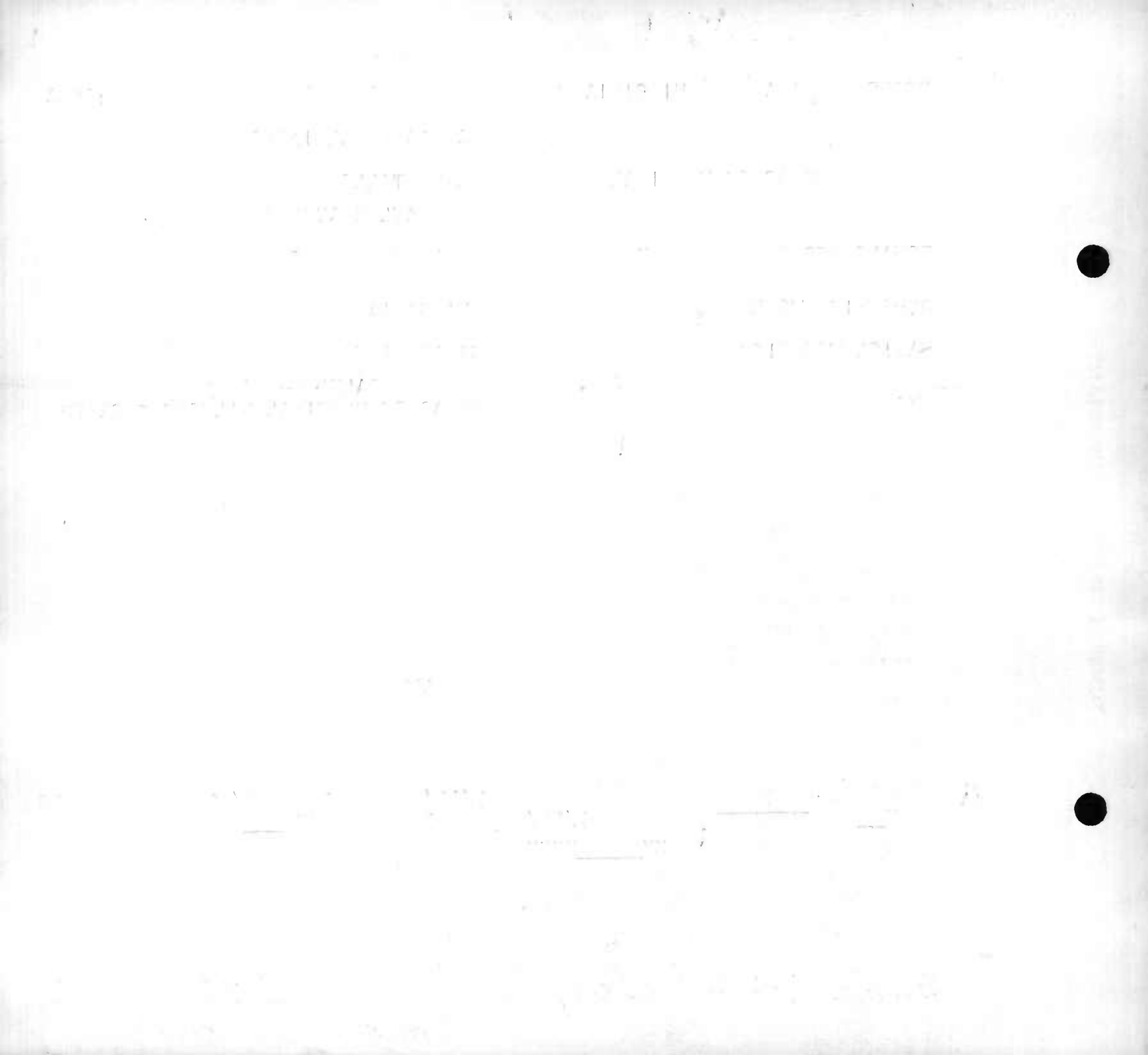
MADE IN U.S.A.

U.S.A.

FUNERAL DIRECTOR: IMPORTANT

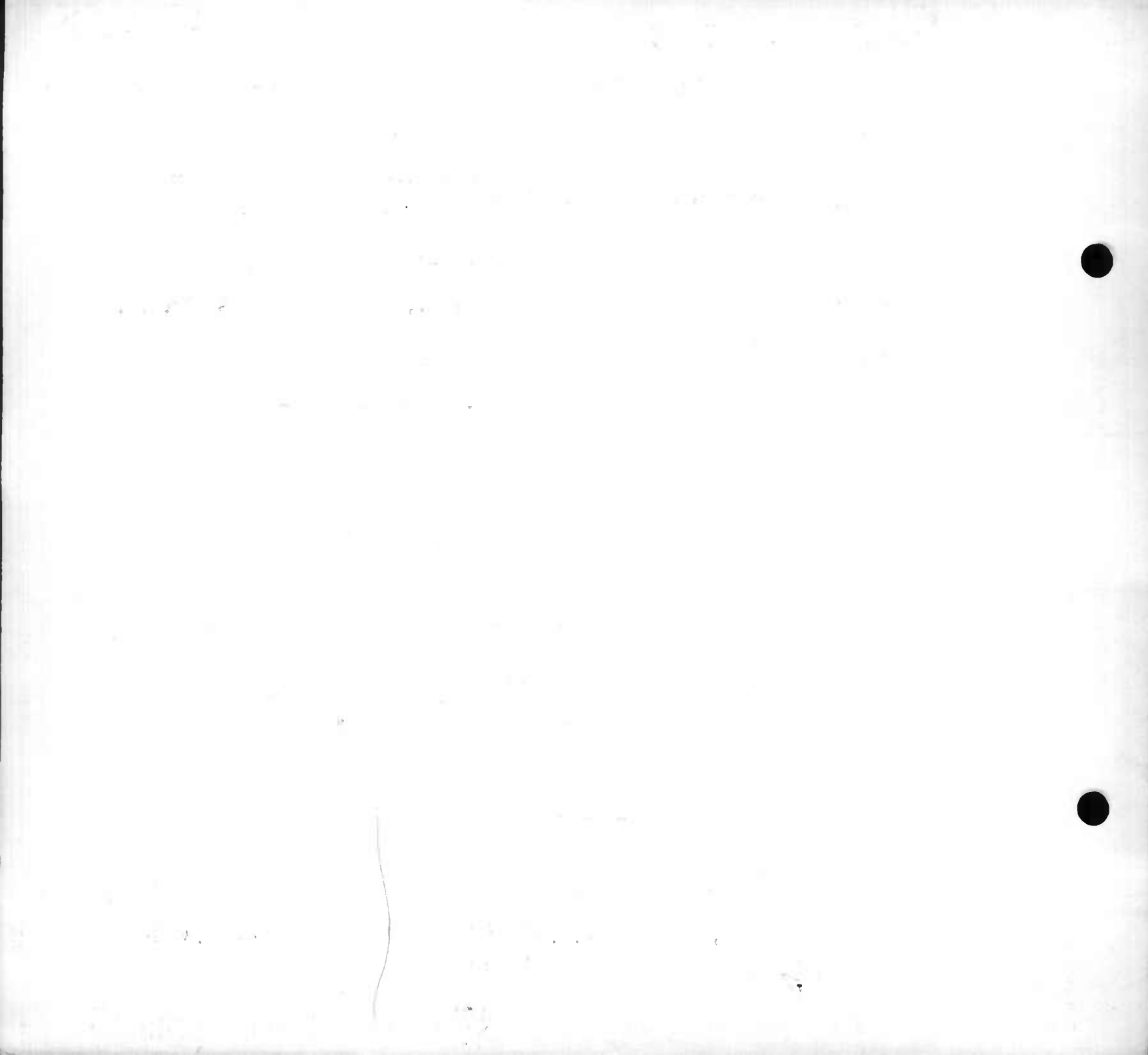
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 7575</u>	
BIRTH NO. <u>B-500</u>		70 7575			
1. NAME OF DECEASED (Type or Print) <u>BOONE, IDA VIRGINIA</u>			2. DATE AND HOUR OF DEATH <u>7 24 70</u> <u>8:10 A M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>ST AGNES HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>CATONSVILLE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>404 TAYLOR AVENUE</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 30 80</u>	9. AGE (In years last birthday) <u>89</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC WORK</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
13. FATHER'S NAME <u>DANIEL WOODRICH</u>			14. MOTHER'S MAIDEN NAME <u>SARAH PAYNE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>BALTO MD 21229</u> ADDRESS <u>ST AGNES HOSPITAL WILKENS & CATON</u>	
18. <u>410.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>MI, Pneumonia, Occlusion of abd. aorta.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>7/24/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (IX) (this hospital) attended the deceased from <u>7/17/70</u> to <u>7/24/70</u> that (IX) (we) last saw the deceased alive on <u>7/24/70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above <u>XX</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ching-Hui Tsai, M.D.</u> DEGREE				23B. DATE SIGNED <u>7/24/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ching-Hui Tsai, M.D.</u> DEGREE				23D. ADDRESS <u>St Agnes Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-28-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Asbury Cem White Marsh Balto Co. Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 31 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Rodger Sanders 5176 Preston St</u> ADDRESS	



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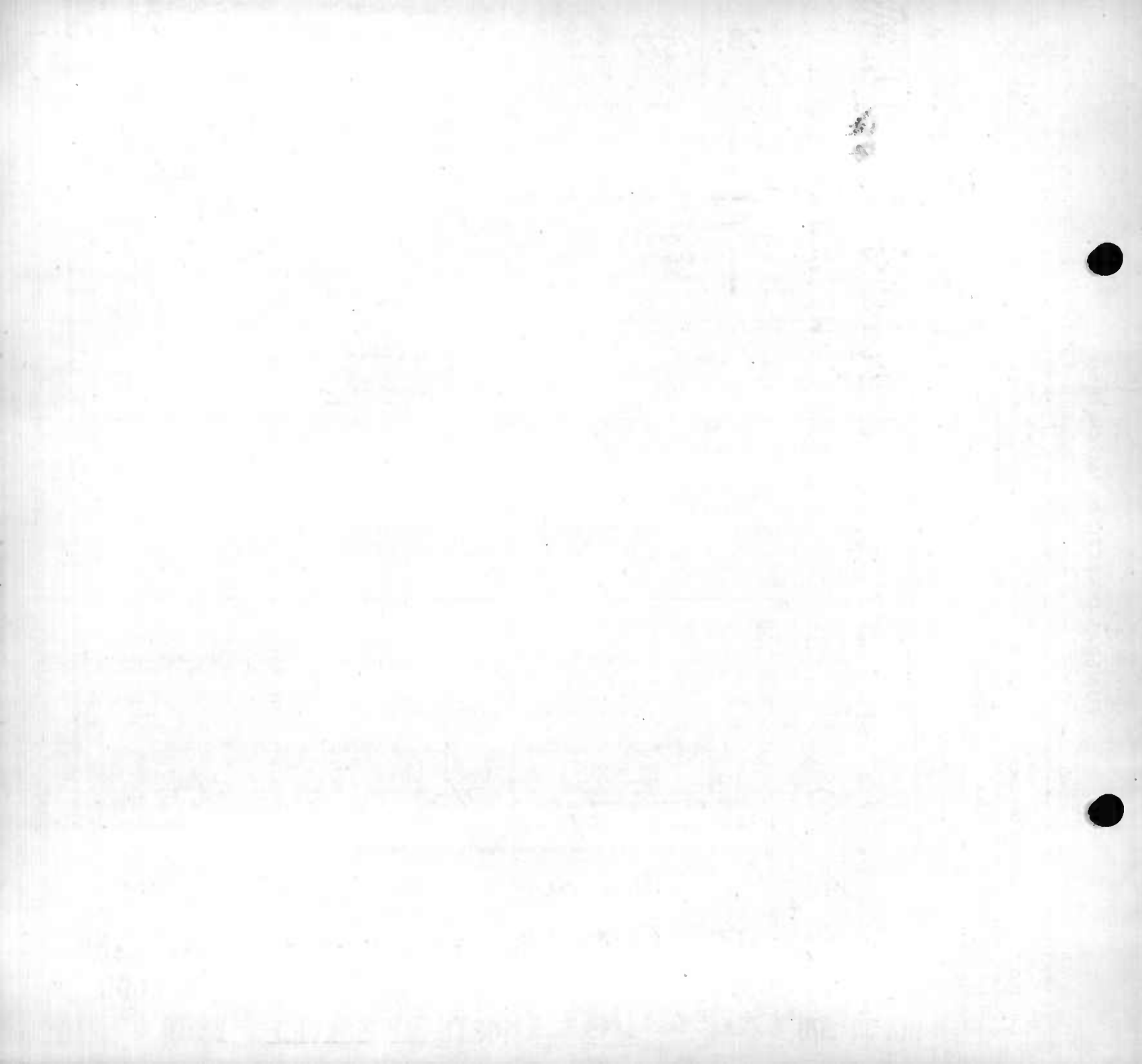
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 7576	
BIRTH NO. R.632 70 7576					
1. NAME OF DECEASED (Type or Print) Richardson Marie		2. DATE AND HOUR OF DEATH 7/26/70 11 Pm.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hosp. Inc.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1514 Division Street Baltimore, Maryland 2217		A. STATE Maryland	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1529 Druid Hill Avenue 14-02			
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-11-08	9. AGE (In years last birthday) 61
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto., Maryland	
13. FATHER'S NAME George Matthews		14. MOTHER'S MAIDEN NAME Brown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Louise Simpson-Friend	
				ADDRESS SAME	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Intestinal obstruction 7 days	
				(B) Cardiac arrest hrs.	
				(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerotic Heart disease					
19A. DATE OF OPERATION 7/26/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/23/70 19____ to 7/26/70 19____ that (I) (we) last saw the deceased alive on 7-26-70 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Madhav D. Barhanpurka				23B. DATE SIGNED 7/26/70	
23C. PHYSICIAN'S NAME (Type) Madhav Barhanpurka,		23D. ADDRESS M.D. ANATOMY BOARD OF MARYLAND University Medical School Baltimore, Maryland 21217			
24A. BURIAL CREMATION, REMOVAL (Specify) 7-29-70		24B. DATE		24C. NAME of CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. ADDRESS MORTUARY SERVICE - BCHD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
BIRTH NO. <u>70-12213</u>		<u>70</u>		<u>7577</u>	
1. NAME OF DECEASED (Type or Print) <u>Baby boy Serio</u>		2. DATE AND HOUR OF DEATH <u>7/21/70</u> <u>9 15</u> <u>PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>AT</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hosp.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>89 Waterview Drive</u>	
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/21/70</u>	9. AGE (In years last birthday) <u>1 day</u>	If Under 1 Yr. Months: <u>7</u> Days: <u>21</u> If Under 24 Hrs. Hours: <u>9</u> Min. <u>15</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>no</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>no</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Joseph Serio</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Serio</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>chart</u>	
18. <u>727X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>prematurity</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>7/21</u> 19 <u>70</u> to <u>7/21</u> 19 <u>70</u> , that (I) (we) lost saw the deceased alive on <u>7/21</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Sang Yoon Rhim M.D.</u>		23B. DATE SIGNED <u>7/21/70</u>		23C. PHYSICIAN'S NAME (Type) <u>SANG YOON RHIM M.D.</u>	
23D. ADDRESS <u>South Baltimore General Hospital</u>		23E. BOARD OF MARYLAND		23F. UNIVERSITY MEDICAL SCHOOL	
23G. MORTUARY SERVICE - BCHD		23H. FUNERAL DIRECTOR		23I. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>7-29-70</u>		24C. NAME OF CEMETERY or CREMATOR <u>Robert E. Taylor, M.D.</u>	
24D. LOCATION (City, town, or county)		24E. STATE		24F. DATE REC'D BY HEALTH DEPT. <u>JUL 31 1970</u>	
24G. NAME OF REGISTRAR		24H. DATE		24I. NAME OF REGISTRAR	



FUNERAL DIRECTOR: IMPORTANT

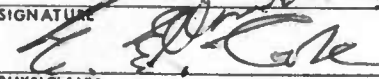
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-500 70 7578		BALTIMORE CITY HEALTH DEPARTMENT		X		70 7578	
BIRTH NO.				70 7578			
1. NAME OF DECEASED (Type or Print) DOWNEY, JR. M.D., FRED M.				2. DATE AND HOUR OF DEATH July 30, 1970 4:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE TENN. B. COUNTY ✓-39			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL BALTIMORE, MARYLAND 21205.				C. CITY OR TOWN NASHVILLE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4630 MOUNTAINVIEW DRIVE			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 11, 1935	9. AGE (In years last birthday) 35 YRS.	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN				10B. KIND OF BUSINESS OR INDUSTRY MEDICAL		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME FRED McEWEN DOWNEY			
14. MOTHER'S MAIDEN NAME LORRAINE BEASLEY				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 1962-1963			
16. SOCIAL SECURITY NO. 211-26-7192				17. INFORMANT MRS. FRED M. DOWNEY			
18. ADDRESS SAME				19. CAUSE OF DEATH RECURRENT CRANIOPHARYNGEOMA AND HYDROCEPHALUS			
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). RECURRENT CRANIOPHARYNGEOMA AND HYDROCEPHALUS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ABOUT 3 DAYS.			
19A. DATE OF OPERATION July 27 & 29, 1970				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED HYDROCEPHALUS & INTRACEREBRAL HEMATOMA			
20A. AUTOPSY? (Yes or No) YES				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 27, 1970 to July 30, 1970 that (I) (we) last saw the deceased alive on July 30, 1970 and that (in my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE CHHABI BHUSHAN - M.D.B.S., L.M.E.C.				23B. DATE SIGNED July 30, 1970			
23C. PHYSICIAN'S NAME (Type) CHHABI BHUSHAN, M.D.B.S., L.M.E.C.				23D. ADDRESS The Johns Hopkins Hospital, Baltimore, Md. 21205			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal-Burial		24B. DATE 7-31-70		24C. NAME of CEMETERY or CREMATORY Mt. Olivet		24D. LOCATION (City, town, or county) (State) Nashville Tenn.	
25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co., Balto., Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

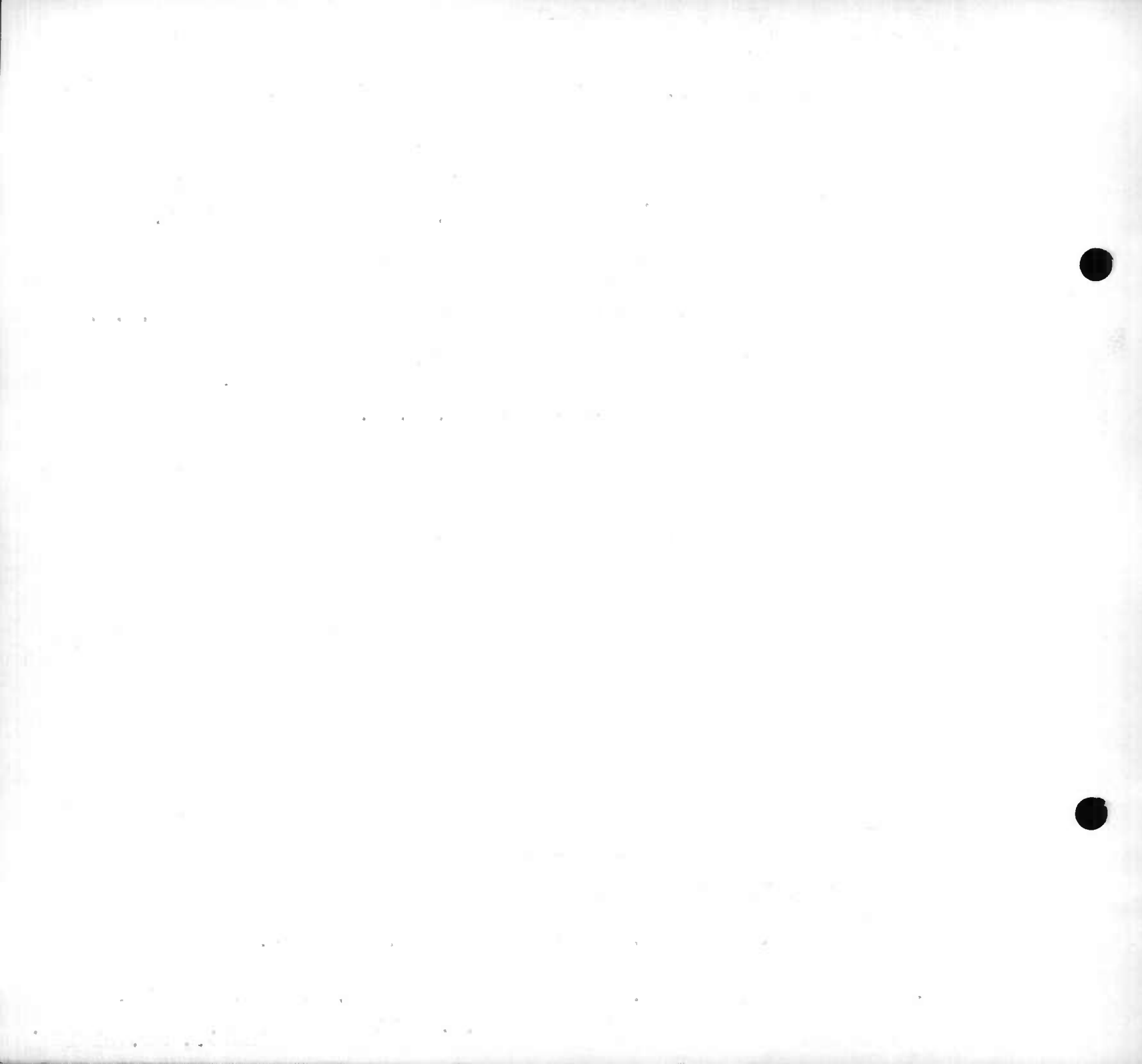
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7579	
S-536 70 7579				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SANDERS, Bernard William (Sr.)		July 31, 1970		2:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
Bolton Hill Nursing & Convalescent Ctr.		Maryland			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Solicitor		Sunpapers		11-10-04	
11. BIRTHPLACE (State or foreign country)		9. AGE (In years last birthday)		12. CITIZEN OF WHAT COUNTRY	
Maryland		65		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
William Joseph Sanders		Wilhelmenia Krol			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		215-05-4224		Bernard W. Sanders, Jr.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		Myocardial infarction		one month	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE		one month	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Carcinoma, left lung			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from 7-8-70 to 7-31-1970 that (I) (we) last saw the deceased alive on 7-31-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				7-31-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
E ELLSWORTH COOK M.D.				2431 MARYLAND AVE. BALTIMORE MD 21218	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		8/3/70		Loudon Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 31 1970		Robert E. Jenkins, M.D.		H. W. Jenkins & Sons Co.	
				ADDRESS 4905 York Rd Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

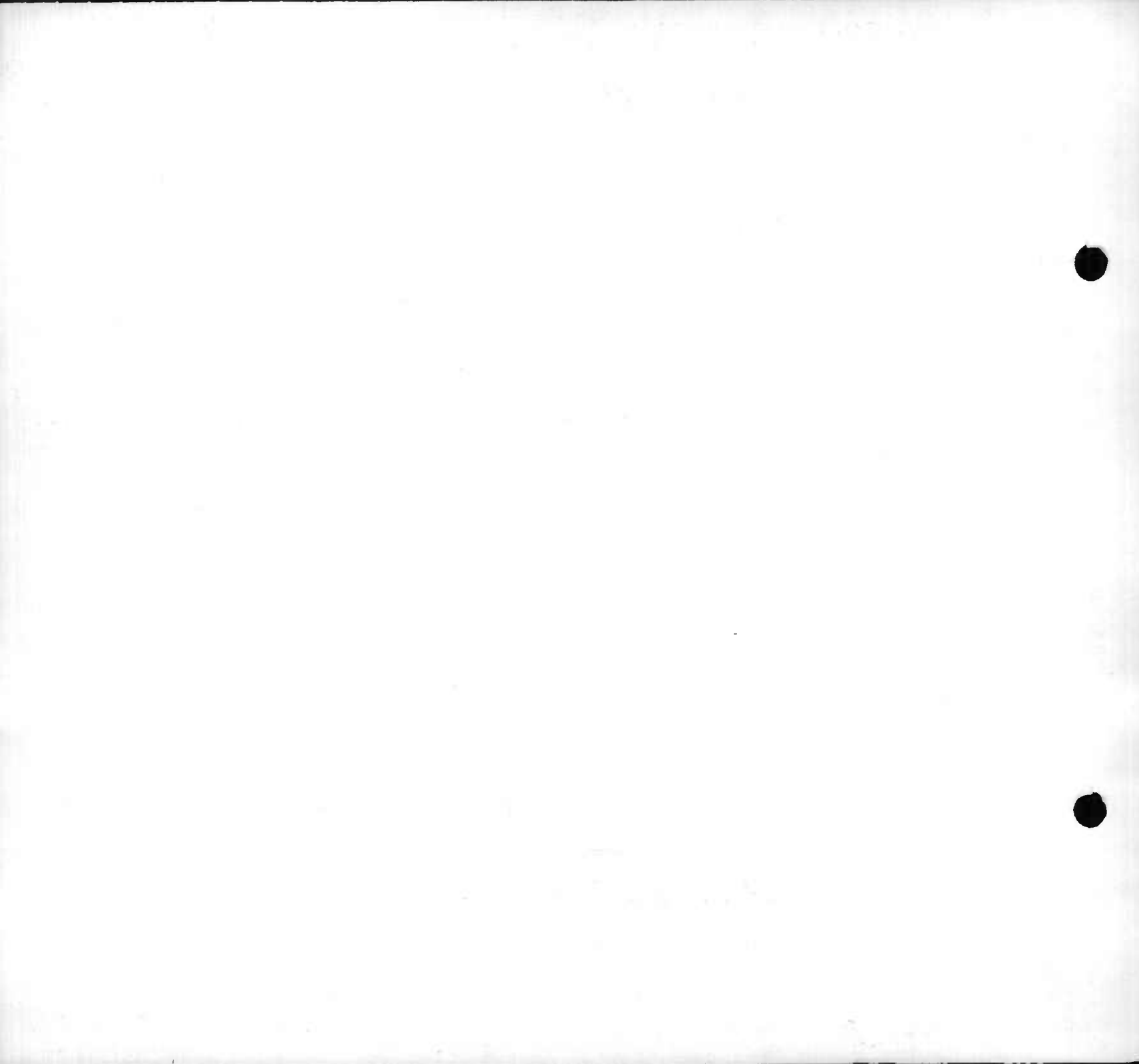
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7580	
BIRTH NO. 4-400 70 7580		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Euphemia G. Hull		2. DATE AND HOUR OF DEATH July 29, 1970 3:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Ambassador Apts.		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Apt. 610, Ambassador Apts. 12-01			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/30/1879	9. AGE (in years last birthday) 91	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Scotland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert Galloway			
14. MOTHER'S MAIDEN NAME Harriet Alexander		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 555-12-1553		17. INFORMANT ADDRESS Mrs. A. K. Galloway (Same)			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardiovascular Dis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Cardiovascular Dis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 yrs. +	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(B) DUE TO, OR AS A CONSEQUENCE OF: Gangrene of Right Leg.		(C) DUE TO, OR AS A CONSEQUENCE OF: 3 mos.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 19 57 to July 29 1970 that (I) (we) last saw the deceased alive on July 24 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Robert W. Garis, M.D.		23B. DATE SIGNED July 30, 1970		23C. PHYSICIAN'S NAME (Type) Dr. Robert W. Garis	
23D. ADDRESS 12 E. Eager St.		24A. BURIAL CREMATION, REMOVAL (Specify) Rem. Entombment			
24B. DATE 7/30/70		24C. NAME OF CEMETERY OR CREMATORY St. Thomas'		24D. LOCATION (City, town, or county) (State) St. Thomas', Ontario, Canada	
25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

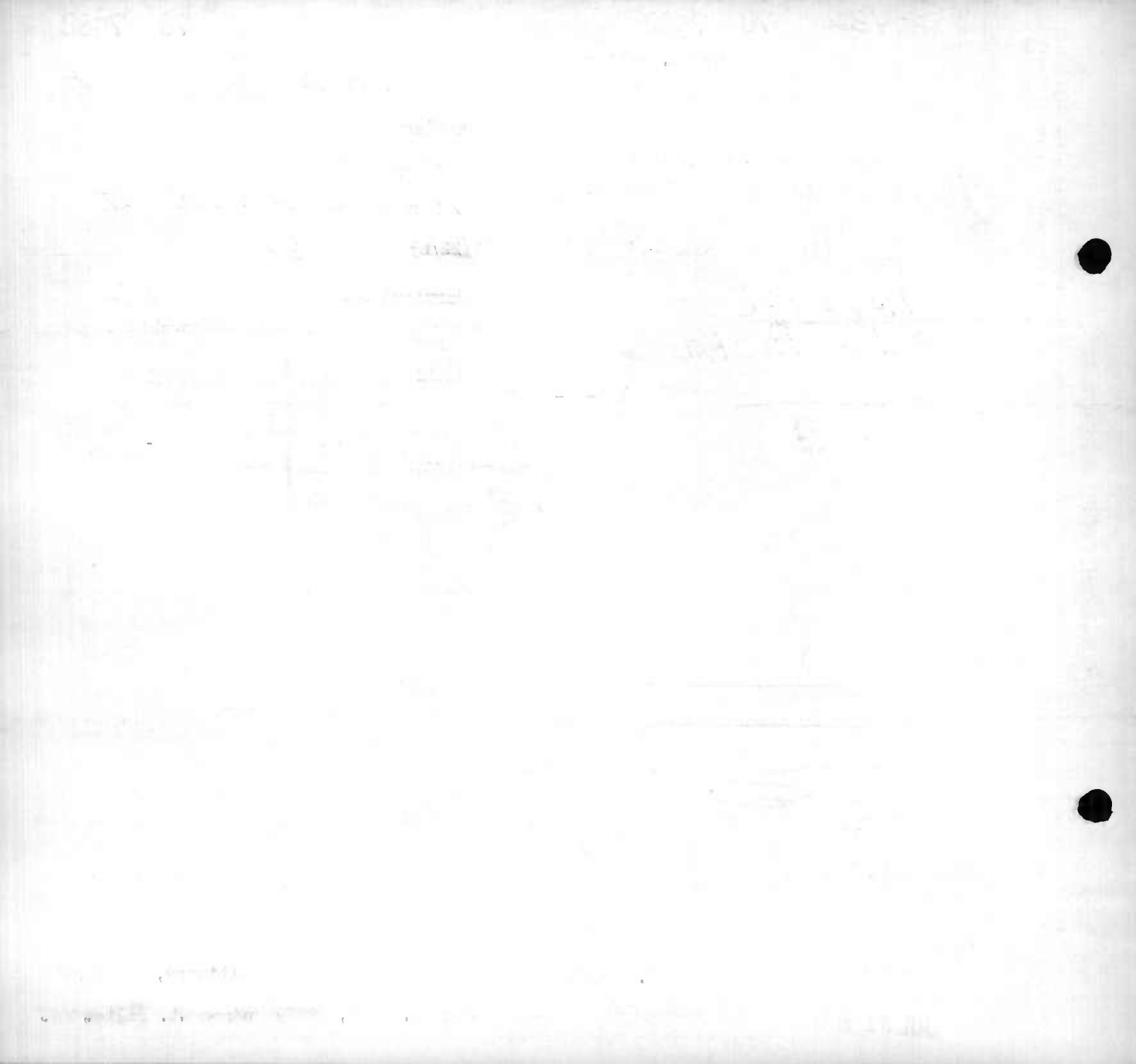
11-520 70 7581		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7581	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>James Minish</i>		2. DATE AND HOUR OF DEATH <i>7/29/70</i> <i>10:30 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Midtown Nursing Home</i>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M.</i>	6. RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/13/1886</i>	9. AGE (in years last birthday) <i>83</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>		11. BIRTHPLACE (State or foreign country) <i>N. Carolina</i>	
13. FATHER'S NAME <i>Jim Minish</i>		14. MOTHER'S MAIDEN NAME <i>Jane ?</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>239-26-2489</i>		17. INFORMANT <i>Mr. Edward P. Minish</i>	
18. <i>185-X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Cardio Respiratory Failure</i> (A) IMMEDIATE CAUSE <i>Carcinoma of Prostate</i> <i>Generalized Bone Metastasis</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2/223</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 25</i> 19 <i>70</i> to <i>July 29</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>July 29</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <i>William Appleford</i>		23B. DATE SIGNED <i>7/30/70</i>		23C. PHYSICIAN'S NAME (Type) <i>William Appleford</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/31/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Green Haven Cem.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 31 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>John G. Gorman & Son, Inc.</i>	
25D. ADDRESS <i>6615 Westview Ave.</i>		25E. ADDRESS <i>901 Hollins St.</i>		25F. ADDRESS <i>93 N. ...</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

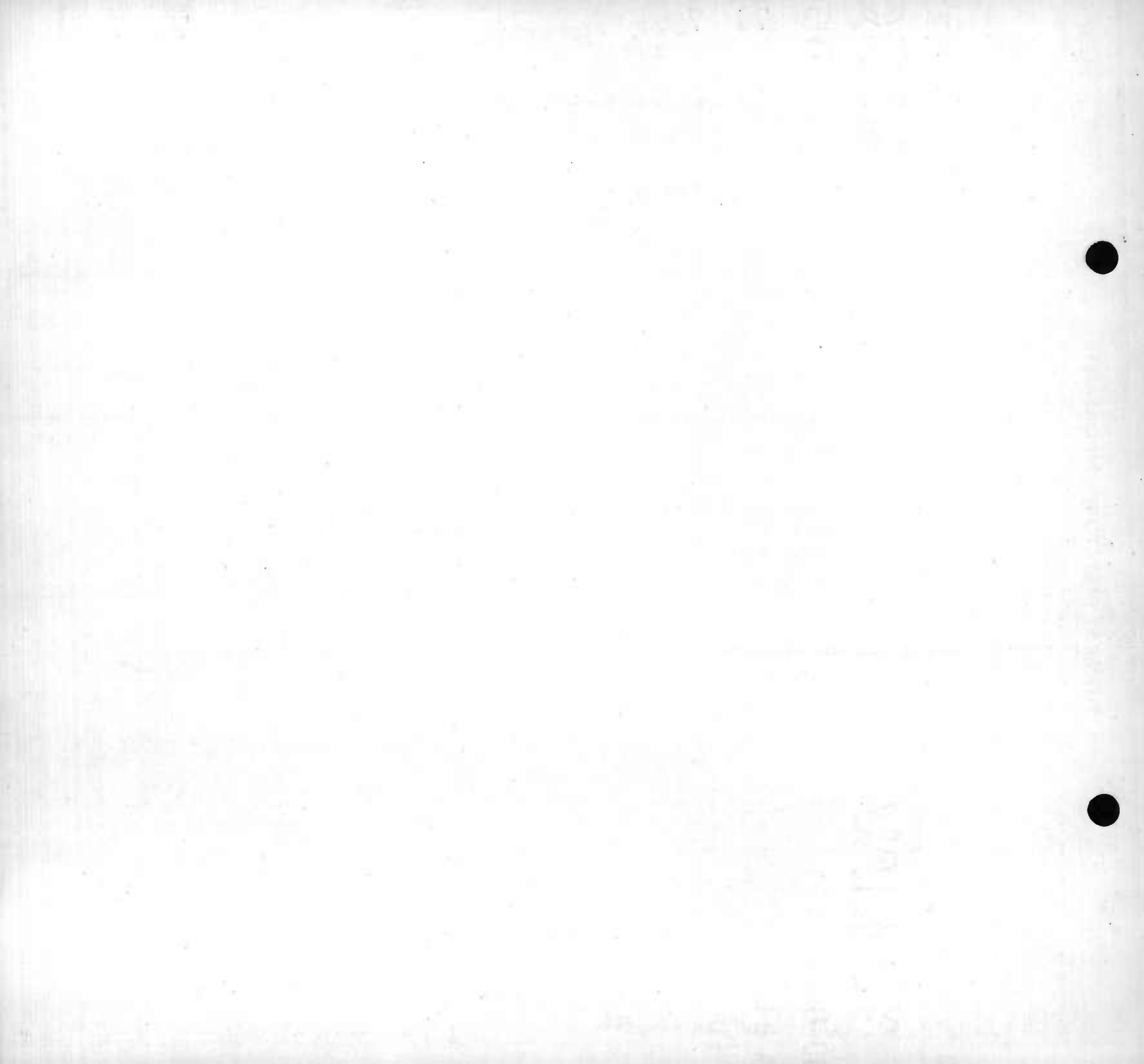
BIRTH NO. S-432 70 7582		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 7582	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MARY Mary A. Soltys		2. DATE AND HOUR OF DEATH 7/29/70 2:20 A			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Maryland General Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. 26-11			
		D. STREET ADDRESS (If rural, give location) 1027 S. BOULDIN ST.			
5. SEX Female	6. RACE Cauc	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED (specify) Widowed	8. DATE OF BIRTH 11/22/03	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland MD	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Andrew Paskala		14. MOTHER'S MAIDEN NAME Amelia Rutkowski			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-03-5807D		17. INFORMANT Dorothy Soltys Daughter	
				ADDRESS same.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 250.01		CAUSE OF DEATH DIABETES MELLITUS (A) DUE TO CARDIAC ARREST & Keto acidosis		INTERVAL BETWEEN ONSET AND DEATH 8 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from 7-28-1970 to 7-29-1970 , that (I) <u>(we)</u> last saw the deceased alive on 7-29-1970 and that in my <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.					
23A. SIGNATURE Whitney Houghton		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/29/70	
23C. PHYSICIAN'S NAME (Type) WHITNEY HOUGHTON		M.D. ADDRESS MD. GEN'L. HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/1/70	24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) BALTO Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970		25B. NAME OF REGISTRAR Robert E. Tabor, MD		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 2829 Hudson St. Balto., Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7583</u>	
J-525 70 7583		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or print) <u>ALICE JOHNSON</u>		2. DATE AND HOUR OF DEATH <u>7/29/70</u> <u>7:26</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>25-05</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SOUTH BALTIMORE GEN. HOSP.</u> <u>3001 S. HANOVER ST.</u> <u>BALTIMORE MD. 21230</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1649 CEDDOX ST #26</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/22/02</u>	9. AGE (In years lost birthday) <u>67</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>George BRIGHTWELL</u>		14. MOTHER'S MAIDEN NAME <u>ELIZ.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>FAM. / 1</u> ADDRESS <u>Rome</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>250.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>CARDIAC ARREST.</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>MYOCARDIAL INFARCTION</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>DIABETES MELLITUS.</u> (C) _____		19. DATE OF OPERATION <u>0</u>		20A. AUTOPSY? (Yes or No)	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>7/13</u> 19 <u>70</u> to <u>7/29</u> 19 <u>70</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>7/29</u> 19 <u>70</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Martin J. Shuman M.D.</u>				23B. DATE SIGNED <u>7/29/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>MARTIN J. SHUMAN MD</u>				23D. ADDRESS <u>3001 S. HANOVER ST.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-1-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cedar Hill Cemetery</u>	
24D. LOCATION <u>Balto, Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JUL 31 1970</u>			
25A. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25B. FUNERAL DIRECTOR <u>John N. Hahn, 4200 Pennington Ave</u>		25C. ADDRESS <u>4200 Pennington Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7584	
BIRTH NO. M-600		70 7584		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) James S. Morrow			2. DATE AND HOUR OF DEATH 7/27/1970 9:35 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto. C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4 Upland Rd. 27-14		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1882	9. AGE (In years last birthday) 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Sect Treas.			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME James Morrow		
14. MOTHER'S MAIDEN NAME Anna Fogelman			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 216017954			17. INFORMANT ADDRESS Ethel M. Morrow 4 Upland Rd.		
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 45%;"> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) </div> </div>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years +					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 7/25		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/25 19 62 to 7/27 19 70 that (I) (we) last saw the deceased alive on 7/26 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Frank Supplee, III				23B. DATE SIGNED 7/29/70	
23C. PHYSICIAN'S NAME (Type) J. Frank Supplee, III				23D. ADDRESS 1010 St. Paul St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7 30 70		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Woodlawn Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Mitchell Wiedefeld Home 6500 York Rd.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 7585		70 7585	
CERTIFICATE OF DEATH				X		REG. NO.	
1. NAME OF DECEASED (Type or Print) Katherine E. McCollough				2. DATE AND HOUR OF DEATH July 27, 1970			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bolton Hill Nursing Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto.			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 8010 Harford Rd.		5-3-00	
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/4/1893	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Jacob F. Saylor				14. MOTHER'S MAIDEN NAME Amelia C. Seidel			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 216281472 A		17. INFORMANT ADDRESS Andrew H. McCollough 8010 Harford Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 436.01 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebro-vascular accident				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertension (B) DUE TO, OR AS A CONSEQUENCE OF: several months (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A)							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natively medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-23-1970 to 7-27-1970 , that (I) (we) last saw the deceased alive on 7-27-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. Ellsworth Cook M.D.				23B. DATE SIGNED 7-30-70			
23C. PHYSICIAN'S NAME (Type) E. Ellsworth Cook M.D.				23D. ADDRESS 2431 Maryland Ave. Balto MD 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/30/70		24C. NAME OF CEMETERY or CREMATORY Lorraine Cemetery		24D. LOCATION (City, town, or county) (State) Dagwood Rd. Woodlawn Balto Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 31 1970		25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home 6500 York Rd			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 70 7586 CERTIFICATE OF DEATH				REG. NO. 70 7586	
BIRTH NO. C-423		1. NAME OF DECEASED (Type or Print) CHILCOTE, JOHN ORICH			
2. DATE AND HOUR OF DEATH 7/29/70 1:55 P M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 53-00		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 6513 Corkley Road		5. SEX Male 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 6/10/17		9. AGE (in years last birthday) 53		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) repairman	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John B. Chilcote	
14. MOTHER'S MAIDEN NAME Helen Hobbs		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 9/10/41 - 1/26/46		16. SOCIAL SECURITY NO. 217-09-8803	
17. INFORMANT VA Hospital Records		ADDRESS 3900 Loch Raven Boulevard, Baltimore, Md			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Carcinoma of Esophagus</u> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7-8 weeks	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>July 28th</u> 19 <u>70</u> to <u>July 29th</u> 19 <u>70</u> that (1) (we) last saw the deceased alive on <u>July 29th</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		23A. SIGNATURE Kenneth Marshall Jr. M.D. DEGREE MD			
23B. DATE SIGNED July 29, 1970		23C. PHYSICIAN'S NAME (Type) Kenneth Marshall Jr. M.D. DEGREE MD			
23D. ADDRESS 3900 Loch Raven Blvd. Baltimore, Md 21218		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 8/3/70		24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE BY HEALTH DEPT. JUL 31 1970		25B. NAME OF REGISTRAR Robert E. Talley, R.D.		25C. FUNERAL DIRECTOR Leonard J Ruck Inc Baltimore, Maryland	

James M. Stewart

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	70 7587
BIRTH NO. H-532		70 7587		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Paul E. Heintzleman</u>			2. DATE AND HOUR OF DEATH <u>July 29/1970 920 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>The Gould Convaleserium</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO</u>		
5. SEX <u>MALE</u> 6. RACE <u>WHITE</u>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Feb 2, 1896</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>B&O. R.R. Coal pier</u>			11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		9. AGE (In years lost birthday) <u>74 yrs.</u>
13. FATHER'S NAME <u>Andrew Heintzman</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>188-12-5112</u>		17. INFORMANT <u>DANIEL W. Long, ATTY</u>
18. <u>4-12-31-009-2</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Gastro-enteritis</u>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Heart Disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
			(B) <u>Middle Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>?</u>		<u>?</u>
			(C) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>?</u>		<u>?</u>
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/5</u> 19 <u>66</u> to <u>7/29</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>7/28</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Louis F. Kline</u>				23B. DATE SIGNED <u>7/29/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>LOUIS F. KLINE S. M.D.</u>				23D. ADDRESS <u>2623 E. Monument St. Baltimore Md. 21205</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/1/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Salem United Brethren</u>	
24D. LOCATION (City, town or county) (State) <u>FRANKLIN Co. PA</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 31 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>	
25C. FUNERAL DIRECTOR <u>L. J. Ruck Inc. BALTO MD 21214</u>		25D. ADDRESS			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
REG. NO. 70 7588									
C-245 70 7588									
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) <i>Chisolm, Roosevelt</i>					2. DATE AND HOUR OF DEATH <i>7-29-70 11PM</i>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>THE JOHNS HOPKINS HOSPITAL</i>					A. STATE <i>MARYLAND</i>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					B. CITY OR TOWN <i>BALTIMORE</i>				
					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
					E. STREET AND NUMBER <i>2704 MURR STREET</i>				
					8-4-3				
5. SEX <i>M</i>		6. RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-06-35</i>		9. AGE (in years last birthday) <i>34</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
<i>Burner Bethlehem Shipyard</i>		<i>Fairfield County S.C.</i>		<i>Fairfield County S.C.</i>					
13. FATHER'S NAME <i>DAVID CHISOLM</i>					14. MOTHER'S MAIDEN NAME <i>MARY HOLLY</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <i>Betty A. Chisolm</i>		
18. <i>70 309</i>					CAUSE OF DEATH			ADDRESS <i>2704 Murr St</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					<i>Subarachnoid Hemorrhage</i>			<i>9 days</i>	
ANTECEDENT CAUSES					(B) DUE TO, OR AS A CONSEQUENCE OF:				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) _____				
II					GI HEMORRHAGE			3 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <i>7-22-70</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Coronary Artery</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>7/20</i> 19 <i>70</i> to <i>7/29</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>7/20</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Hamid</i>					23B. DATE SIGNED <i>7/29/70</i>				
23C. PHYSICIAN'S NAME (Type) <i>N. HAMID</i>					23D. ADDRESS <i>JOHNS HOPKINS HOSPITAL, BALTIMORE, MD.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		15101	
<i>Removal</i>						<i>Blackstone, S. Carolina</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 31 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Ellis Funeral Home</i>		ADDRESS <i>1129 N. Caroline</i>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7589	
BIRTH NO. 620 70 7589				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) PIERCE, Clarence			2. DATE AND HOUR OF DEATH 7/29/70 7:45 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2208 E. Federal Street 8-02		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 6, 1935 XXXXXX42	9. AGE (in years last birthday) 37 35	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Halifax Co., Va.	
13. FATHER'S NAME John E. Pierce			14. MOTHER'S MAIDEN NAME Ida Florence		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Florence Pierce ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE Septic Shock DUE TO, OR AS A CONSEQUENCE OF: (B) ? infected ascites DUE TO, OR AS A CONSEQUENCE OF: (C) Laennec's Cirrhosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY Yes or No NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner).		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 28 1970 to July 29 1970 that (I) (we) last saw the deceased alive on July 29 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. R. Austin, M.D.			23B. DATE SIGNED 7/29/70		
23C. PHYSICIAN'S NAME (Type) STEVEN R. Austin, M.D.			23D. ADDRESS 550 No. Broadway, Baltimore		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/1/1970		24C. NAME OF CEMETERY OR CREMATORY Florida Hill Mem. Garden	
24D. LOCATION Ringgold, Va.		24E. DATE REC'D BY HEALTH DEPT. JUL 31 1970		24F. NAME OF REGISTRAR George L. Schwab Inc. Balto., Md.	
24G. FUNERAL DIRECTOR George L. Schwab Inc.		24H. ADDRESS 2101 Fred. Ave			

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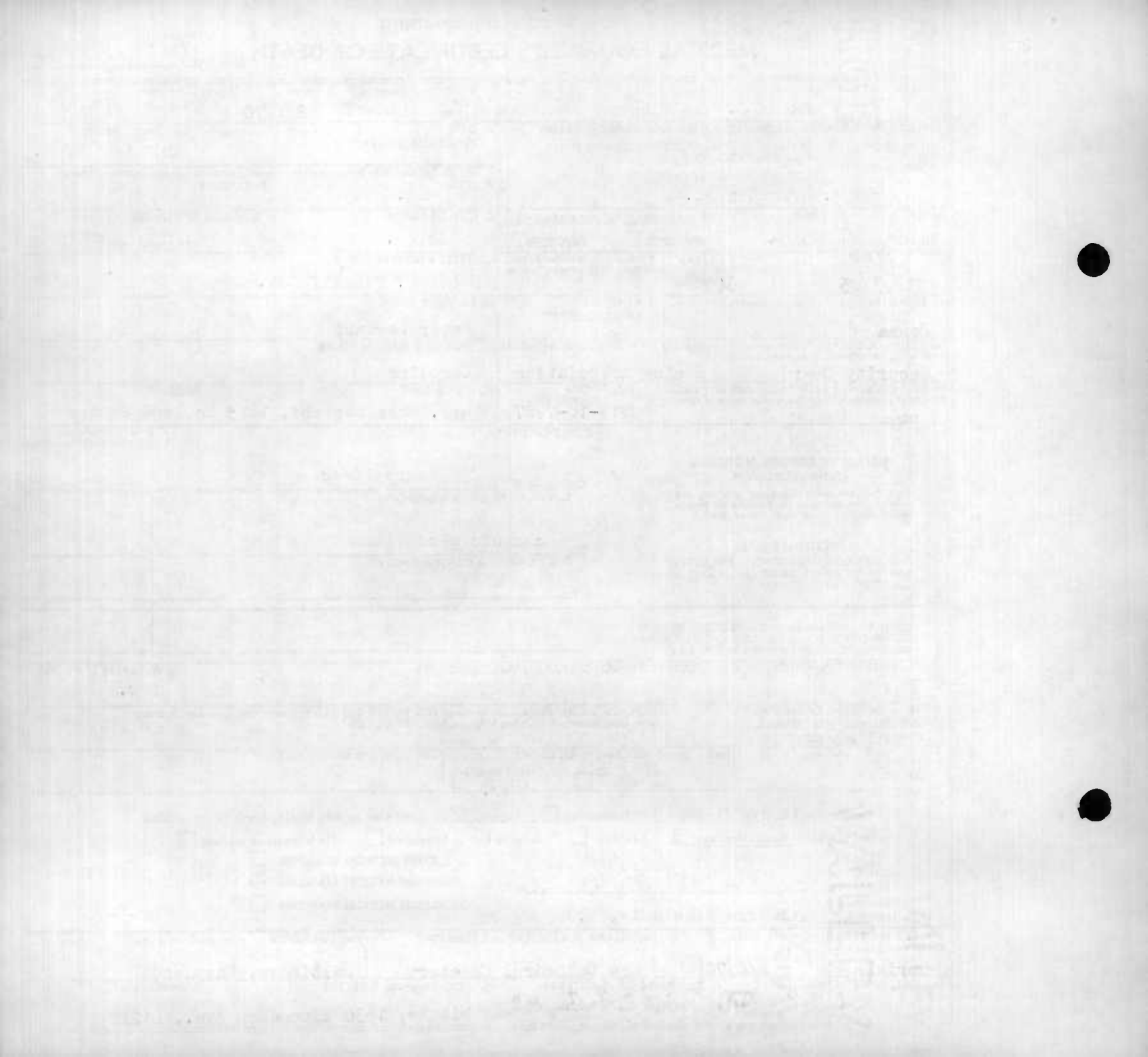
70 7590

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7590

BIRTH NO.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 8/1/70 M.	
1. NAME OF DECEASED (Type or Print) FRANK J. LE GAMBI		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 1 1970 5:37 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 508 W. Franklin St.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1701	
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.
9. DATE OF BIRTH 11/23/05	10. AGE (In years lost birthday) 64	11. BIRTHPLACE (State or foreign country) Penna	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
12. CITIZEN OF WHAT COUNTRY? USA		E. STREET AND NUMBER 508 W. Franklin St.	
13. FATHER'S NAME Peter Legambi		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Security Guard	
15. MOTHER'S MAIDEN NAME Caroline		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 219-10-7987		18. INFORMANT Mrs. Rose Legambi, 1015 Howland Square	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: chronic alcoholism (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Par.			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 8-1-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/4/70	24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970	25B. NAME OF REGISTRAR Robert E. Taber, M.D.	25C. FUNERAL DIRECTOR ADDRESS Witzke, 1630 Edmondson Ave., 21228	



FUNERAL DIRECTOR: IMPORTANT

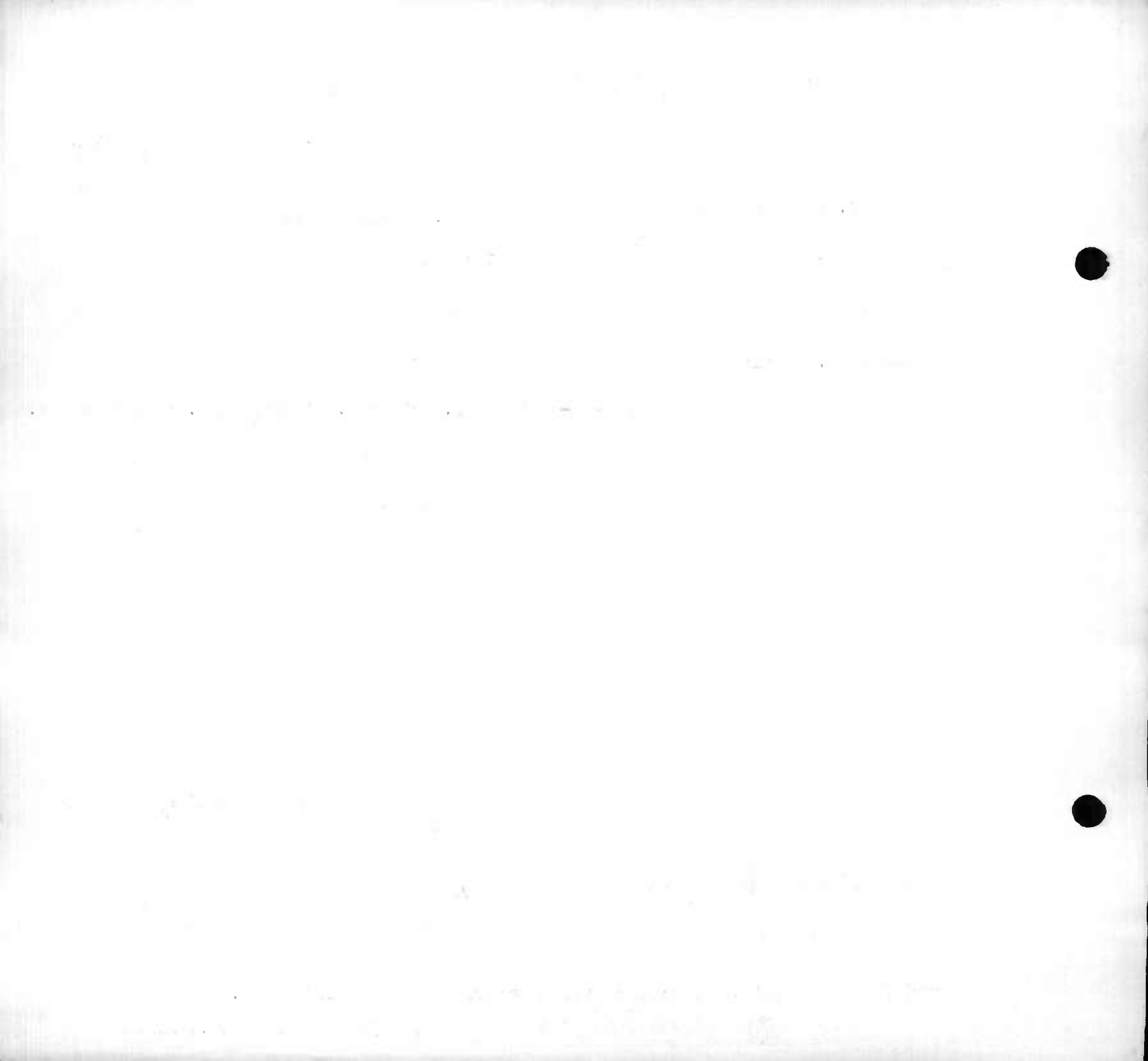
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7591	
70 7591				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GLENN V. RALEIGH		2. DATE AND HOUR OF DEATH 8/1/70 at 3 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1102			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL 44		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 519 N. CHARLES STREET			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/21/03	9. AGE (in years last birthday) 67	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CALIFORNIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME RALEIGH, William		14. MOTHER'S MAIDEN NAME Garthright (D)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WW2 8/5/42-8/20/45		16. SOCIAL SECURITY NO. 217-09-2370		17. INFORMANT ADDRESS Mrs. Glenn Raleigh, 519 N. Charles St.	
18. 4/2/31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CONGESTIVE HEART FAILURE CORONARY ARTERY DISEASE		CAUSE OF DEATH BRONCHOPNEUMONIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE (B) DUE TO, OR AS A CONSEQUENCE OF: CORONARY ARTERY DISEASE (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 07-03 19 70 to 08-01 19 70 that (I) (we) last saw the deceased alive on 07-31 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Khoury		H.D. DEGREE M.D.		23B. DATE SIGNED 08-01-70	
23C. PHYSICIAN'S NAME (Type) JACQUES KHOURY		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/4/70		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Witzke, 4101 Edmondson Ave., 21229			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		X		REG. NO. 70 7592	
BIRTH NO. 70 7592		1. NAME OF DECEASED (Type or Print) Mr. Walter RIPLE		2. DATE AND HOUR OF DEATH 8/1/1970 355 A. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Md. B. COUNTY Balto. 5300		C. CITY OR TOWN Catonsville		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/15/01		9. AGE (In years last birthday) 68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Everett N. Ripple				14. MOTHER'S MAIDEN NAME Carrie Cole					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-01-2441A		17. INFORMANT ADDRESS Mrs. Walter W. Ripple, 10 S. Beechwood Ave.					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acut MS H.A.S.C.V.1		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs. years			
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1968 to 8/1/1970 that (I) (we) last saw the deceased alive on 8/1/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE [Signature] DEGREE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8/1/1970			
23C. PHYSICIAN'S NAME (Type) ADRIAN M. SONMEZ DEGREE				23D. ADDRESS 1011 Frederick Rd. Baltimore Md. 21228					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/4/70		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) Baltimore, Md.		(State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave., 21228		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7593	
BIRTH NO. 70 7593		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ARNOLD YOUNTS		2. DATE AND HOUR OF DEATH JULY 30, 1970 10:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL Hospital 43		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE CITY 2553			
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISABLED		10B. KIND OF BUSINESS OR INDUSTRY Retired Cab Driver		11. BIRTHPLACE (State or foreign country) N.C.	
13. FATHER'S NAME Cosmos Younts		14. MOTHER'S MAIDEN NAME MARY KNUCKLES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 217-01-7369		17. INFORMANT MARY C. DELKER	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple emboli; acute pulmonary		CAUSE OF DEATH Multiple emboli; acute pulmonary		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Poly cythemia		(B) DUE TO, OR AS A CONSEQUENCE OF: Chronic obstructive lung disease	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Smert Sresh				23B. DATE SIGNED 7/30/70	
23C. PHYSICIAN'S NAME (Type) Smert Sresh				23D. ADDRESS South Baltimore, General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/3/70		24C. NAME OF CEMETERY or CREMATORY Lorraine Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970			
25B. NAME OF REGISTRAR Robert E. Fisher, MD.		25C. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave. 21229			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7594	
F-425 BIRTH NO. 70 7594		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Eva M. Fleishmann (Fleischmann)</i>		2. DATE AND HOUR OF DEATH <i>July 29, 1970</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Century Nursing Home</i> <i>102 N. Paca Street</i>		A. STATE <i>Maryland</i> B. COUNTY <i>602</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F.</i>		E. STREET AND NUMBER <i>formerly 2713 E. Fayette St.</i>	
6. RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>7/30/'88</i>	9. AGE (In years lost birthday) <i>81</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Caroline County, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>George Bascom Taylor</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Rosella Neighbors</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. Ernest G. Fleishmann</i>		ADDRESS <i>8308 Karl Ave</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Cardio-Respiratory Failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Arteriosclerotic C.V.D.</i> <i>Gen. Cerebral Arteriosclerosis</i> <i>Chr. Brain Syndrome</i>			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <i>0</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>May 3</i> 19 <i>70</i> to <i>July 25</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>July 29</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.			
23A. SIGNATURE <i>William D. Appleberry</i> DEGREE <i>MD</i>			23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <i>William D. Appleberry</i> DEGREE <i>MD</i>			23D. ADDRESS <i>6615 Reisterstown Rd</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>8/11/70</i>	24C. NAME of CEMETERY or CREMATORY <i>Moreland Memorial Park Cemetery, Baltimore, Maryland</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 3 1970</i>	25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	25C. FUNERAL DIRECTOR ADDRESS <i>John A. Moran, Inc. 3000 E. Baltimore St.</i>	

Charles - Baptist, London
Guthrie - Baptist, C. 1844
Geo. G. G. G. G. G.
The Bostonian

Wm. Lloyd Garrison
*
London, England 1844

July 20 - 1844

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

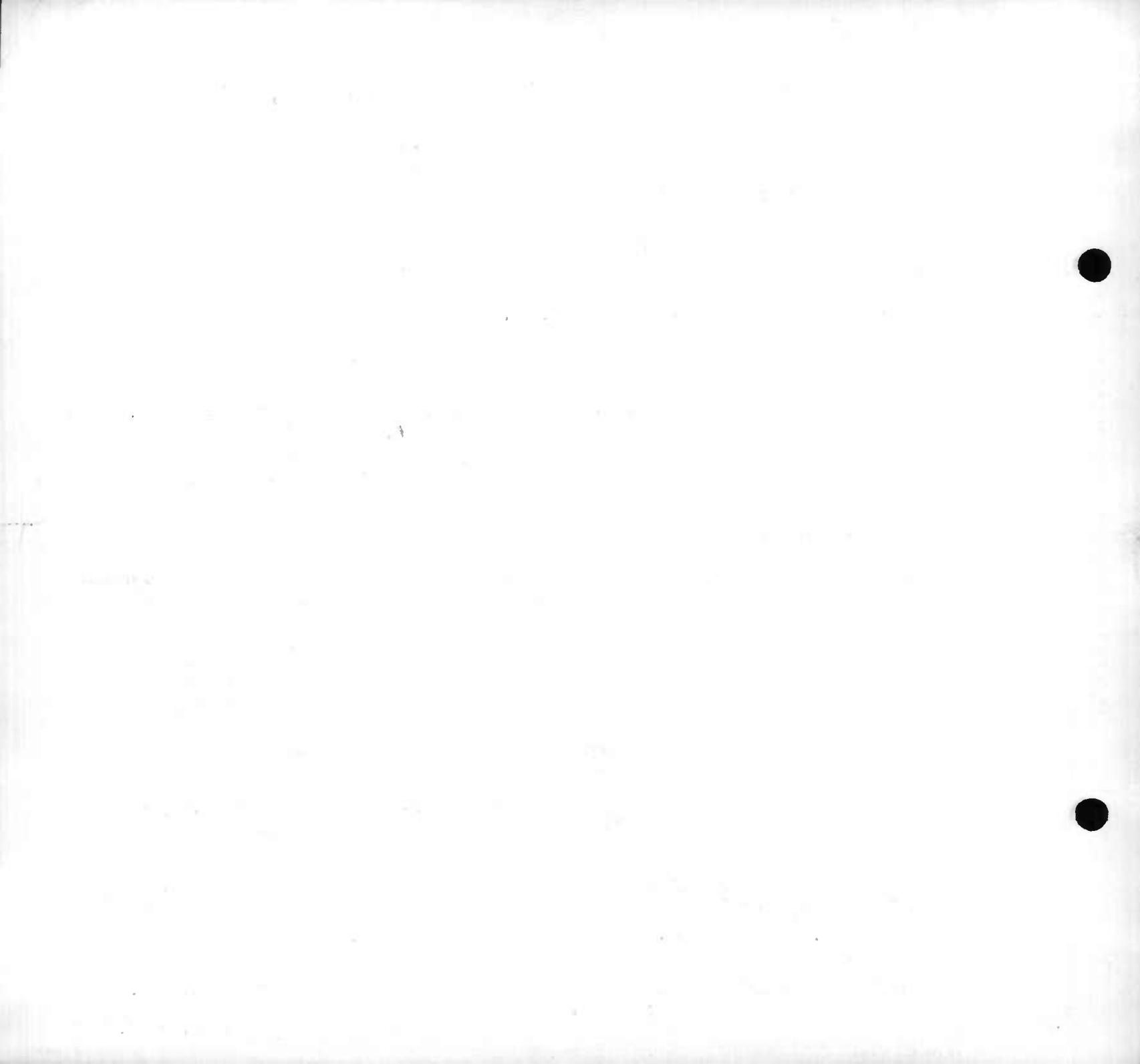
B-163 70 7595		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7595	
1. NAME OF DECEASED (Type or Print) MOZELL ROBERTS		2. DATE AND HOUR OF DEATH 7-30-70 6:55 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSP. - 3001 S. HANOVER ST.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2534			
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 6 JEFFREY ST.			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8:20:15	9. AGE (in years last birthday) 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME WALTER F. PENNIGER			
14. MOTHER'S MAIDEN NAME CORA BARTLETT		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. -		17. INFORMANT MEDICAL RECORD - S.B.G.H.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 17481 BREAST CARCINOMA WITH >3 years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH >3 years			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II HYPERTENSION		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: METASTASIS			
		(B) DUE TO, OR AS A CONSEQUENCE OF: -			
		(C) -			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). HYPERTENSION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 7-3-70 to 7-30-70 that (I) (we) last saw the deceased alive on 7-30-70 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. C. UGORJI		23B. DATE SIGNED 7:30, 70			
23C. PHYSICIAN'S NAME (Type) C. C. UGORJI		23D. ADDRESS South Baltimore Gen. Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/1/70		24C. NAME OF CEMETERY or CREMATORY oakwood Cem	
24D. LOCATION (City, town, or county) (State) SILER CITY N.C.					
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR McBully F.H. 737	
				ADDRESS fatness ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

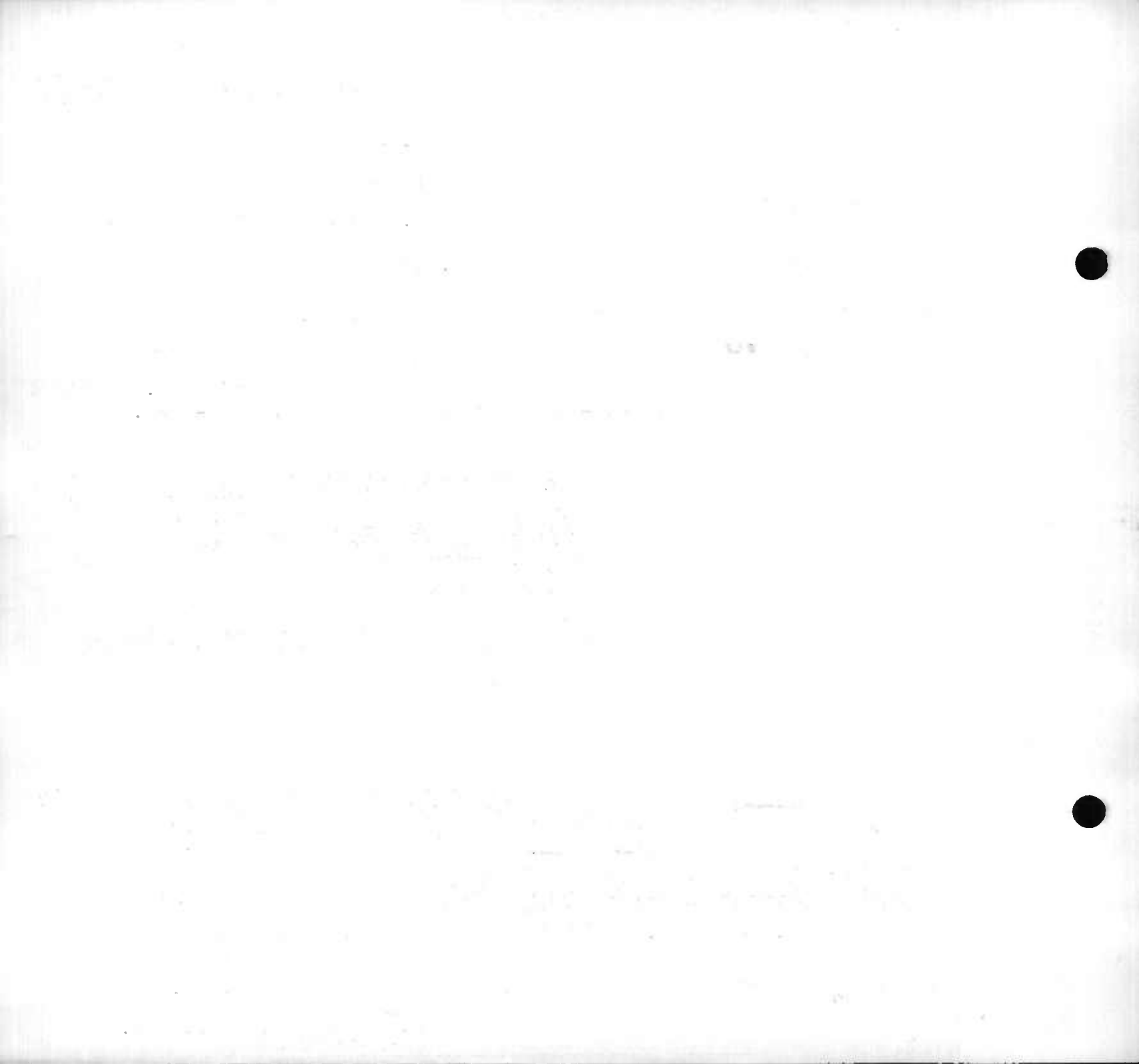
BIRTH NO.		70 7596		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		70 7596	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
Preston Charles McDaniel				July 28, 1970				M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 33 Hopkins Hospital				A. STATE Md., 21205				B. COUNTY 603	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2217 Jefferson Street					
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1902	9. AGE (in years last birthday) 68	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours	13. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10B. KIND OF BUSINESS OR INDUSTRY Daniel Constr. Co.				11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME George McDaniel				14. MOTHER'S MAIDEN NAME Alice Parks	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 215-09-7231				17. INFORMANT Pearl Lively McDaniel, wife, above	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CORONARY OCCLUSION IMMEDIATE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HYPERTENSIO 29 years				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 29 years					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-20-69 19 to 7-28-70 19 that (I) (we) lost saw the deceased alive on 7/25/70 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Dr. Benjamin B. Moses				23B. DATE SIGNED 7/31/70					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS 448 N. Luzerne Avenue					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8/1/70				24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Baltimore, Md.									
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970				25B. NAME OF REGISTRAR Jabari E. Hester, M.D.				25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

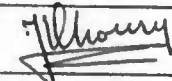
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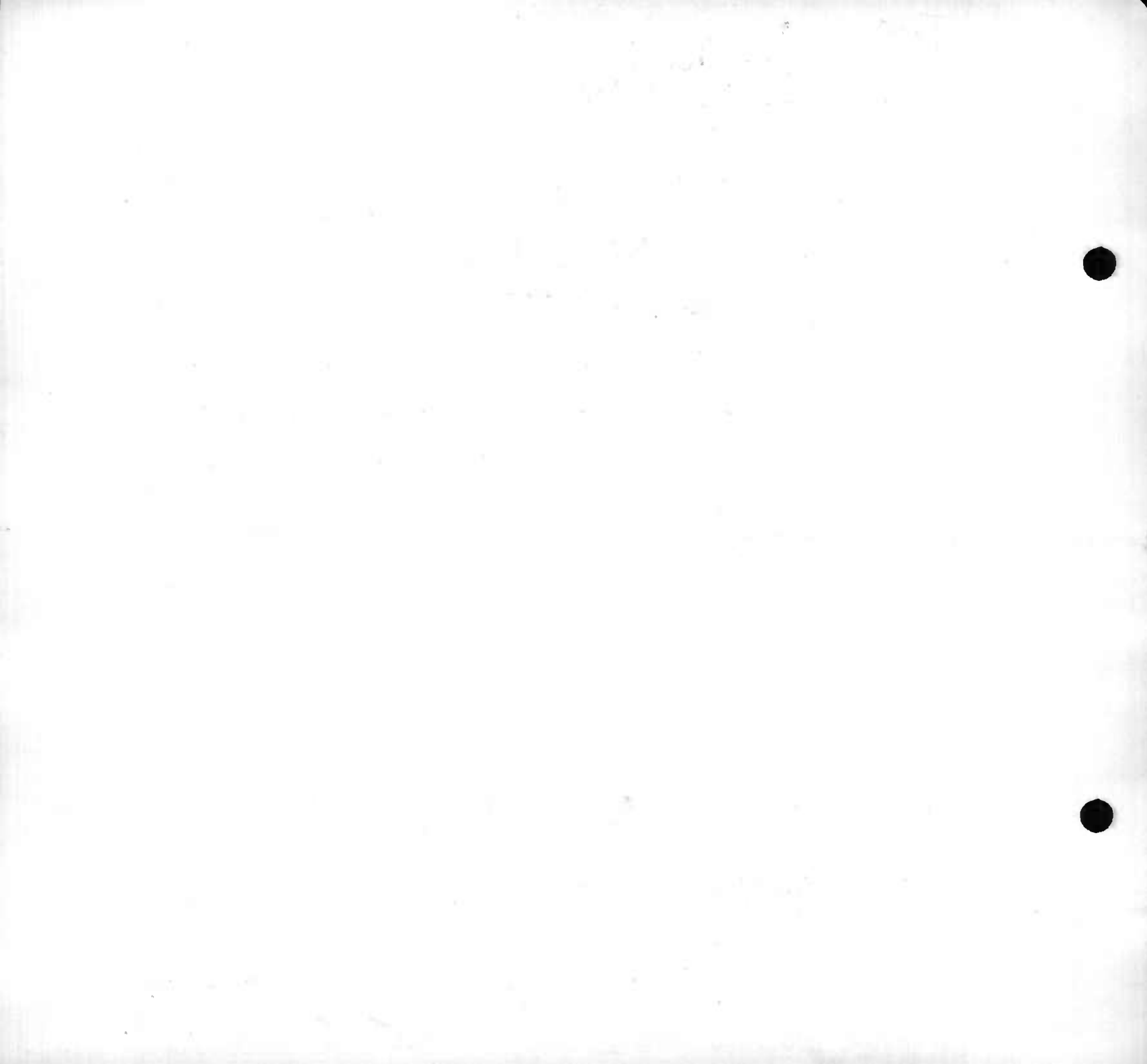
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 7597</u>	
<u>S-100</u> BIRTH NO. <u>70 7597</u>		1. NAME OF DECEASED (Type or Print) <u>IDA SCHEPP</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 Gould Nursing Home</u>		4. DATE AND HOUR OF DEATH <u>July 29, 1970</u> <u>10:10 P.</u> M. A. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>21205</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>917 N. Streeper Street</u>			
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 2, 1880</u>	9. AGE (In years last birthday) <u>90</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <u>unknown</u>			
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>215-03-4173</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>1215 Brook Meadow Dr. ADDRESS 21204</u> <u>Phyllis Gebhardt, grand-dght.</u>			
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Senility; malabsorption; malnutrition</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic myocarditis; cerebral insufficiency</u> (B) <u>Arteriosclerotic C-V Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>acut hemiplegia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>8</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 27, 1967</u> to <u>July 29, 1970</u> that (I) (we) last saw the deceased alive on <u>July 29, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Harold V. Harbold</u>		23B. DATE SIGNED <u>July 31, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Harold V. Harbold</u>	
23D. ADDRESS <u>4706 Harford Road</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>8/1/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>AUG 5 1970</u>		25B. NAME OF REGISTRAR <u>E. J. ...</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>	
ADDRESS <u>3331 Prehms Lane</u>					



FUNERAL DIRECTOR: IMPORTANT

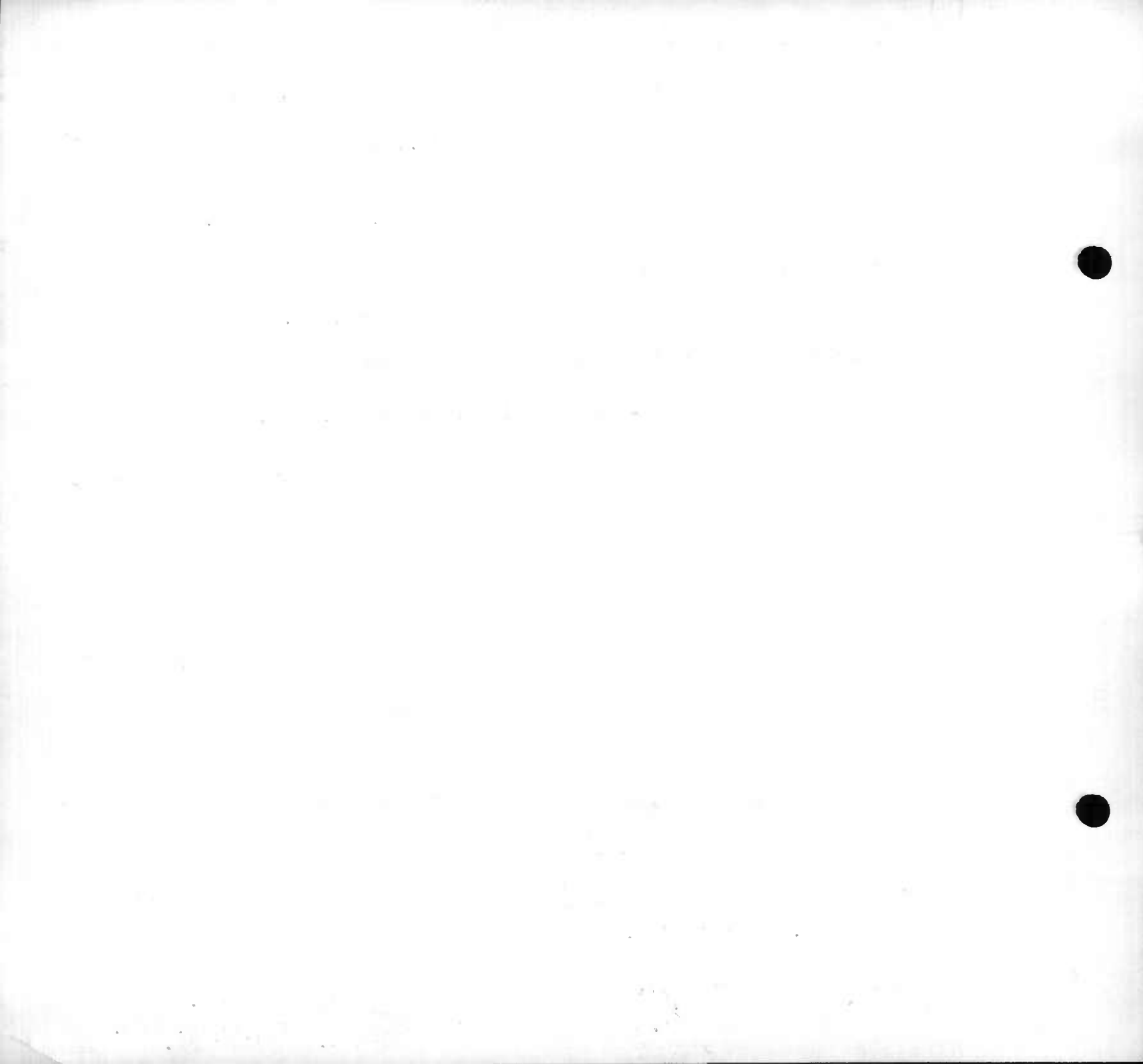
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7598	
T-656 70 7598				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ALBERT W. TRENNER SR.		7/28/70 11.45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
UNION MEMORIAL HOSPITAL			MARYLAND 908		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 738 Bartlett Ave. 21218		
			7917 GREY HAVEN RD 21222		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7/18/00	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
STEEL WORKER (RETIRED)			Beth. Steel		MARYLAND
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?
WILLIAM TRENNER			(D) Frances Birkmeier		U.S.A
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
			215-09-4802		21222
			Edward Trenner, son, 7917 Gray Haven		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
[This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]			ACUTE MYOCARDIAL INFARCTION		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
2					YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If only medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(APPROX.)			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 7/25 1970 to 7/28 1970 that (I) (we) last saw the deceased alive on 7/28 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
			7/29/70 1.15 AM		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
JACQUES KHOURY			UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/1/70		Lorraine Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 3 1970		Robert E. Taber, M.D.		Schimunek Funeral Home, Inc.	
				3331 Brehms Lane	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-640 70 7599		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 7599	
1. NAME OF DECEASED (Type or Print) MATILDA BRILL		2. DATE AND HOUR OF DEATH July 28, 1970 12:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Edgewood Nursing Home		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 21205			
5. SEX female		6. RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9/13/78		9. AGE (In years last birthday) 91		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-56-5998 JI		17. INFORMANT James Brill, son, above	
18. 440.71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Generalized arteriosclerosis		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 14 1967 to July 28 1970 that (I) (we) last saw the deceased alive on July 22 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick J. Vollmer		23B. DAYE SIGNED 7-30-70		23C. PHYSICIAN'S NAME (Type) Dr. Frederick J. Vollmer	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/31/70		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Jolley, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.	
				ADDRESS 6100 York Road Baltimore, Md. 2601 E. Madison St.	

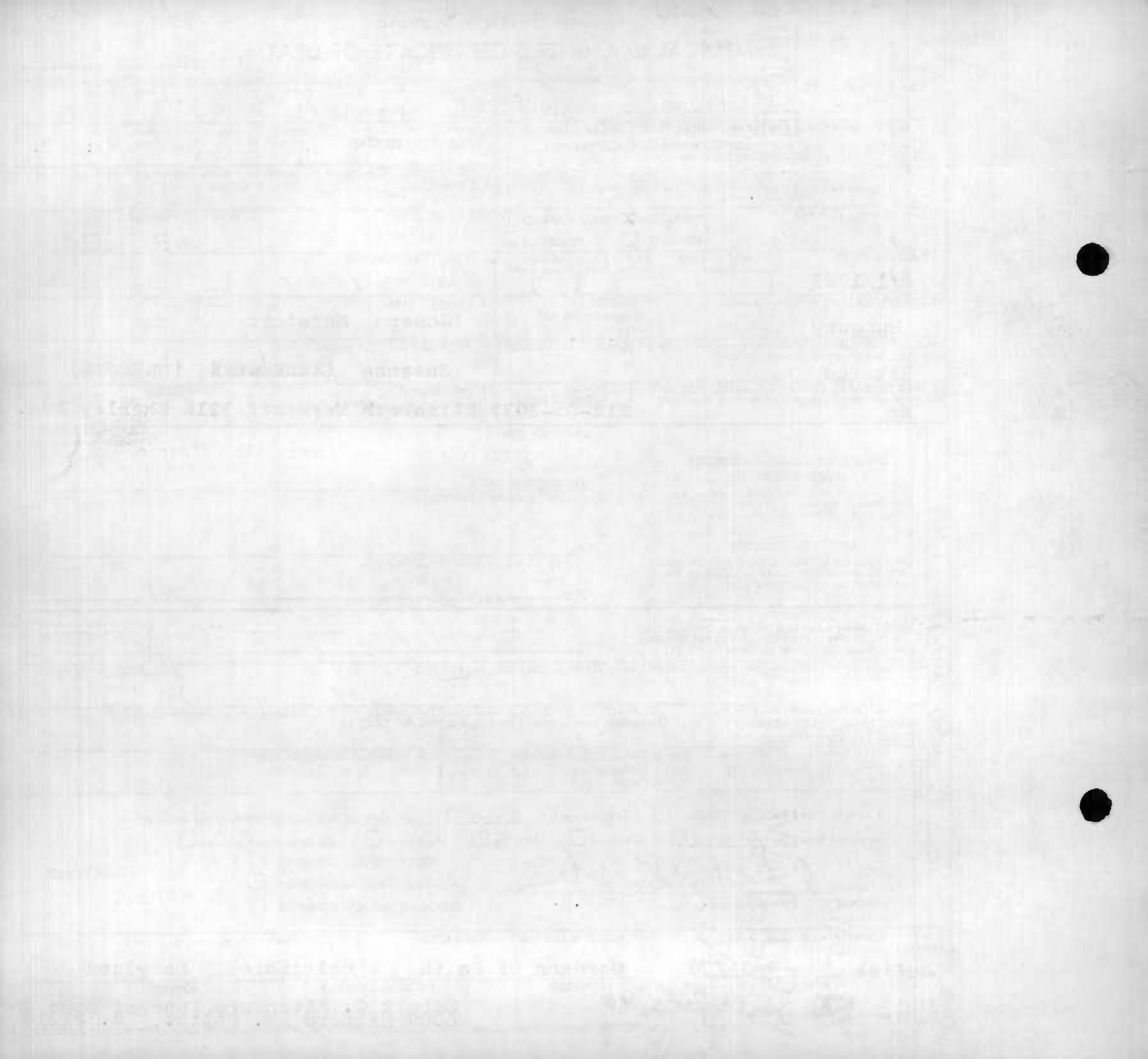


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) JOSEPH MERSTORF		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 SOUTH BALTO. GENERAL HOSPITAL		3. DATE PRONOUNCED DEAD Month		Day	Year	Hour	M.
				July 28, 1970		3:26 P.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland		B. COUNTY 2735					
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 6/1/1903		10. AGE (In years lost birthday) 67	11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Joseph Merstorf		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		15. MOTHER'S MAIDEN NAME Susanne (XXXXXX) (UNKNOWN)			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 214-05-3033		18. INFORMANT ADDRESS Elizabeth Merstorf 3216 Chesley Ave.			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
		(B) DUE TO, OR AS A CONSEQUENCE OF:					
		(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/29/70							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/31/70		24C. NAME of CEMETERY or CREMATORY Gardens Of Faith		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Robert C. Altenburg Funeral Home Inc 6009 Harford Rd. Balto., Md. 21214			

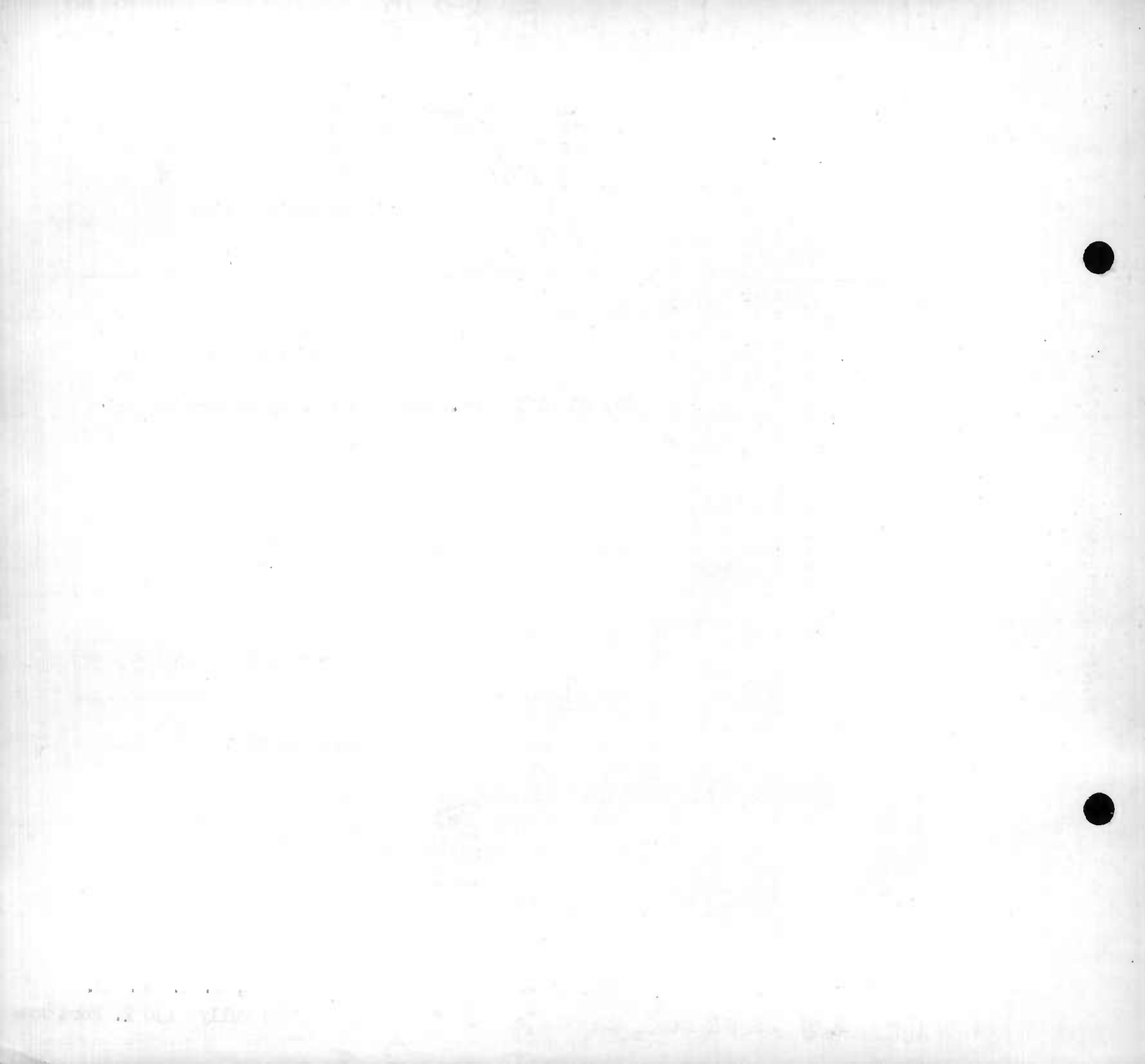


1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
MILTON GROFF		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year July 29 1970		Month Day Year July 29, 1970		A. STATE B. COUNTY Maryland Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION CITY HOSPITAL (DOA)		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4:33 A.M.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. DATE OF BIRTH APRIL 19, 1932		10. AGE (In years lost birthday) 38	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Elwood M. Groff		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakesman		15. MOTHER'S MAIDEN NAME Mildred Vanderpoel	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes Korean War		17. SOCIAL SECURITY NO. 219-28-9028		18. INFORMANT Elwood M. Groff		19. CAUSE OF DEATH Crushed chest and abdomen		20. DATE OF OPERATION 7/31/70	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E804.9		21. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) B&O Track		23. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 500 block E. Fayette Street		24. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) 7-29-70 4:15 A.	
25. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		27. HOW DID INJURY OCCUR? Subject fell off train		28. DATE OF OPERATION 7/31/70		29. CONDITION FOR WHICH OPERATION WAS PERFORMED	
30. DATE OF OPERATION 7/31/70		31. CONDITION FOR WHICH OPERATION WAS PERFORMED		32. AUTOPSY? (Yes or No) yes		33. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		34. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) B&O Track	
35. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) 7-29-70 4:15 A.		36. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		37. HOW DID INJURY OCCUR? Subject fell off train		38. DATE OF OPERATION 7/31/70		39. CONDITION FOR WHICH OPERATION WAS PERFORMED	
40. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		41. ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		42. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		43. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		44. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
45. DATE REC'D BY HEALTH DEPT. AUG 3 1970		46. NAME OF REGISTRAR Robert E. Taylor, M.D.		47. FUNERAL DIRECTOR Lassahn Funeral Home		48. ADDRESS 7401 Bel Air Road		49. DATE SIGNED 7/29/70	
50. BURIAL CREMATION, REMOVAL (Specify) Burial		51. DATE 7/31/70		52. NAME of CEMETERY or CREMATORY Baltimore National Cem.		53. LOCATION (City, town, or county) (State) Baltimore Md.		54. DATE REC'D BY HEALTH DEPT. AUG 3 1970	
55. DATE REC'D BY HEALTH DEPT. AUG 3 1970		56. NAME OF REGISTRAR Robert E. Taylor, M.D.		57. FUNERAL DIRECTOR Lassahn Funeral Home		58. ADDRESS 7401 Bel Air Road		59. DATE SIGNED 7/29/70	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. 70 7602	
BIRTH NO. M-235		70 7602 CERTIFICATE OF DEATH				DATE AND HOUR OF DEATH July 30-70 6³⁰pm.	
1. NAME OF DECEASED (Type or Print) Mc Adams John E.						2. DATE AND HOUR OF DEATH July 30-70 6³⁰pm.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital						4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 2572	
5. SEX male 6. RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>						8. DATE OF BIRTH 12-14-11 9. AGE (In years last birthday) 58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not employed Binder						10B. KIND OF BUSINESS OR INDUSTRY Book Binding	
11. BIRTHPLACE (State or foreign country) Maryland						12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James J. (dec)						14. MOTHER'S MAIDEN NAME Mary Baker, (dec)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes # 2						16. SOCIAL SECURITY NO. 213 03 6159	
17. INFORMANT Mrs. Marie Rowe						ADDRESS 2603 Northshire Drive	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Pul. Edema (B) DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart failure (C) Pul. failure & Renal failure	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sinash, M.D.						23B. DATE SIGNED 7/30/70	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8 3 70		24C. NAME OF CEMETERY or CREMATORY Glen Haven		24D. LOCATION (City, town, or county) (State) Glen Burnie, A. A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.		25C. FUNERAL DIRECTOR Mc Gully		ADDRESS 130 E. Fort Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-621		70 7603		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 7603	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Lillian PRESBURY</i>				2. DATE AND HOUR OF DEATH 7-29-70 11 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Harford</i>				6228			
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> <i>Baltimore, City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland #21224</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Aberdeen</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <i>Female</i>		6. RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 2, 1909</i>		9. AGE (In years last birthday) <i>61</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>William B. Chase</i>		14. MOTHER'S MAIDEN NAME <i>Mary M. Dennison</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-07-0395D</i>		17. INFORMANT ADDRESS <i>Baltimore city Hospitals</i> <i>4940 Eastern Avenue #21224</i>	
18. <i>43391-203X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>② bronchopneumonia</i> (B) <i>Cerebral Thrombosis → ① hemiparesis 7 mos</i> (C) <i>? Multiple Myeloma</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>3/11</i> 19 <i>70</i> to <i>7/29</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>7:30 PM 7/29</i> 19 <i>70</i> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Michael W. Pozen</i>		23B. DATE SIGNED <i>7/29/70</i>		23C. PHYSICIAN'S NAME (Type) <i>Michael Pozen M.D.</i>		23D. ADDRESS <i>BCH 4940 Eastern Avenue</i> <i>Baltimore, Maryland</i>		#21224	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-3-70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Int Calvary Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Aberdeen Harford Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 3 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Elmer E. Bullock</i>		25D. ADDRESS <i>Harford Md.</i>			

1d

post, & delivery

CERTIFICATE OF DEATH

REG. NO.

7604

70 7604

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GERTRUDE E. PENN

2. DATE AND HOUR OF DEATH

7/29/70 at 10:30 AM

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)BALTIMORE CITY HOSPITAL
4940 EASTERN AVE.
BALTIMORE, MD, 212244. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

MARYLAND Baltimore

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER 4940 Eastern Avenue, Baltimore, Md.

1141 RIVERSIDE AVENUE #21224

5. SEX

Female

6. RACE

White

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

1-19-94

9. AGE (In years
lost birthday)

76

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Elevator Operator

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

ROBERT BURGESS

14. MOTHER'S MAIDEN NAME

Esther HARN

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL

SECURITY NO.

212-094580

17. INFORMANT

ADDRESS

Russell Brock-1043 William St. 21230
Records: BCH-4940 Eastern Avenue 21224

18. 440.91

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

PULMONARY EMBOLISM

2 Weeks

(B) ATHEROSCLEROTIC VASCULAR DISEASE

DUE TO, OR AS A CONSEQUENCE OF:

2 years

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A)

CHRONIC BRAIN SYNDROME

SEVERAL years

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At ☐ Not While
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-7-1968 to 7/29/1970,
that (I) (we) last saw the deceased alive on 7/25/1970 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

D. B. RAO

M.D

DEGREE

Attending ☐Med.
Director ☐Staff ☒

23B. DATE SIGNED

7/29/70

23C. PHYSICIAN'S
NAME (Type)

D. B. RAO

DEGREE

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Md. 21224
BALTIMORE CITY HOSPITAL, BALTIMORE, 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-31-70

24C. NAME OF CEMETERY or CREMATORY

Balto National Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 3 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Armacost Funeral Chapel-4600 Liberty Hts

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-523		70 7605		BALTIMORE CITY HEALTH DEPART		REG. NO. 70 7605	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) MISS HELEN B. VON WACHTER			
2. DATE AND HOUR OF DEATH 7-30-70 8:30 A. M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Hood Convalescent Home Inc. 5313 Edmondson Ave. Baltimore, Md. 21229				4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1 N Monroe ST			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-94	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dr Frank Von Wachter				14. MOTHER'S MAIDEN NAME Pfister			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. 244-40-5992		17. INFORMANT Grace L Wootton		ADDRESS 724 Silver Creek Rd	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ch. Myocarditis - Arteriosclerotic Cardio Vascular Disease Diabetes Mellitus				CAUSE OF DEATH 21208 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov. 12 1964 to July 30 1970, that (I) (we) last saw the deceased alive on July 29 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Harry L. Knipp, MD				23B. DATE SIGNED 7-30-70		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) HARRY L. KNIPP, MD				23D. ADDRESS 4116 EDMONDSON AV. BALTO, MD 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-3-70		24C. NAME of CEMETERY or CREMATORY LONDON PARK Cemetery - BALTIMORE, MD		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Anna Cast Funeral Chapel - Heights Ave		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		70 7606		BALTIMORE CITY HEALTH DEPARTMENT		70 7606	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) ROBERT L. GECKLE				2. DATE AND HOUR OF DEATH 7/29/70 0.45 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2802			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4403 LIBERTY HEIGHTS AVENUE BALTIMORE 7 MARYLAND			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/27/22	9. AGE (in years last birthday) 47	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY U.S.A							
13. FATHER'S NAME AUGUST GEGKLE				14. MOTHER'S MAIDEN NAME MARGARET LONG			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.II				16. SOCIAL SECURITY NO. 215-18-7976		17. INFORMANT ADDRESS Dorothy Geckle Sam m tux	
18. CAUSE OF DEATH 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(B) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
19A. DATE OF OPERATION 7/29/70				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/22 19 70 to 7/29/70 19 70 that (I) (we) last saw the deceased alive on 7/29 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. Khoury				23B. DATE SIGNED 7/29/70		23C. PHYSICIAN'S NAME (Type) JACQUES KHOURY	
23D. ADDRESS UNION MEMORIAL HOSPITAL							
24A. BURIAL Burial		24B. DATE 7-31-70		24C. NAME of CEMETERY BALTIMORE NATIONAL		24D. LOCATION (City, town, or county) (State) BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Taber, M.D.		25C. FUNERAL DIRECTOR Wm Cook-Brooks Towson		ADDRESS 1050 York Rd Towson, Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>BIRTH NO. S-620 70 7607</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>Registered No. 70 7607</p>	
<p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <u>FRANK W. SHARKEY Sr.</u></p>		<p>2. DATE AND HOUR OF DEATH <u>8-1-70</u> <u>1:50</u> <u>AM</u></p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md</u> B. COUNTY <u>Anne Arundel</u> 5200 C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Glen Burnie</u> D. STREET ADDRESS (If rural, give location) <u>404 Kent Circle</u></p>	
<p>5. SEX <u>m.</u></p>	<p>6. RACE <u>Cauc</u></p>	<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)</p>	<p>8. DATE OF BIRTH <u>2-5-17</u></p>
<p>9. AGE (In years last birthday) <u>53</u></p>		<p>If Under 1 Yr. Months: Days: Hours: Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>construction</u> 1969</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <u>H.W. Cover Co.</u></p>	
<p>11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>	
<p>13. FATHER'S NAME <u>Wm. Sharkey</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Emma Fithov</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u></p>		<p>16. SOCIAL SECURITY NO. <u>218-05-1899</u></p>	
<p>17. INFORMANT <u>Frank Sharkey</u></p>		<p>ADDRESS <u>59 Menzies Ave. Balto</u></p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><u>5-19-21</u></p>		<p>CAUSE OF DEATH</p> <p>(A) <u>Pneumonia (Serratia marcescens)</u></p> <p>(B) <u>Chronic obstructive lung disease</u></p> <p><u>cardiac hypertrophy</u></p>	
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>INTERVAL BETWEEN ONSET AND DEATH <u>7-19-70 to 8-1-70</u></p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> <p><u>Renal Shutdown, acute</u></p> <p><u>Myocardial Infarct, CHF, Class III</u></p> <p><u>atherosclerotic cardiovascular disease</u></p>			
<p>19A. DATE OF OPERATION <u>2</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <u>No</u></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>7-28</u> - <u>1970</u> to <u>8-1</u> - <u>1970</u>, that (I) (we) lost saw the deceased alive on <u>7-31</u> - <u>1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <u>Whitney Houghton</u> M.D.</p>		<p>23B. DATE SIGNED <u>8-1-70</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>WHITNEY HOUGHTON</u> M.D.</p>		<p>23D. ADDRESS <u>MD GENERAL HOSPITAL</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>8/4/70</u></p>	
<p>24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Memorial Park</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>AUG 3 1970</u></p>		<p>25B. NAME OF REGISTRAR <u>Robert E. Farber, R.D.</u></p>	
<p>25C. FUNERAL DIRECTOR <u>Singleton</u></p>		<p>ADDRESS <u>Funeral Home, Glen Burnie, Md.</u></p>	

24

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7608	
<div style="display: flex; justify-content: space-between;"> B-121 70 7608 X </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) Evelyn Babkoff			2. DATE AND HOUR OF DEATH 7/29/70 1³⁰ A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 45 Good Samaritan Hosp.			A. STATE Md. B. COUNTY BAL.		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 7607 Liberty Rd. 21207		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/18/13		9. AGE (In years last birthday) 57
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Albert Franklin		14. MOTHER'S MAIDEN NAME Mary Franklin (nee Moore)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) X NO		16. SOCIAL SECURITY NO. 215-22-9417		17. INFORMANT ADDRESS Albert Babkoff 7507 Liberty Road 21207	
18. 4/10.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH acute arrhythmia (A) IMMEDIATE CAUSE Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (B) arteriosclerotic cardiovascular DUE TO, OR AS A CONSEQUENCE OF: (C) renal disease.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). hypertension			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7/6/70		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/24 19 70 to 7/29 19 70 , that (I) (we) last saw the deceased alive on 7/28 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Richard J. Powell			23B. DATE SIGNED 7/29/70		23C. PHYSICIAN'S NAME (Type) Reuben E. Taylor, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 8/1/70		24C. NAME of CEMETERY or CREMATORY Morgan Cemetery
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970			25B. NAME OF REGISTRAR Loring Byers		25C. FUNERAL DIRECTOR ADDRESS 8728 Liberty Road 21133
24D. LOCATION (City, town, or county) (State) Carroll County Maryland					

FUNERAL DIRECTOR: IMPORTANT

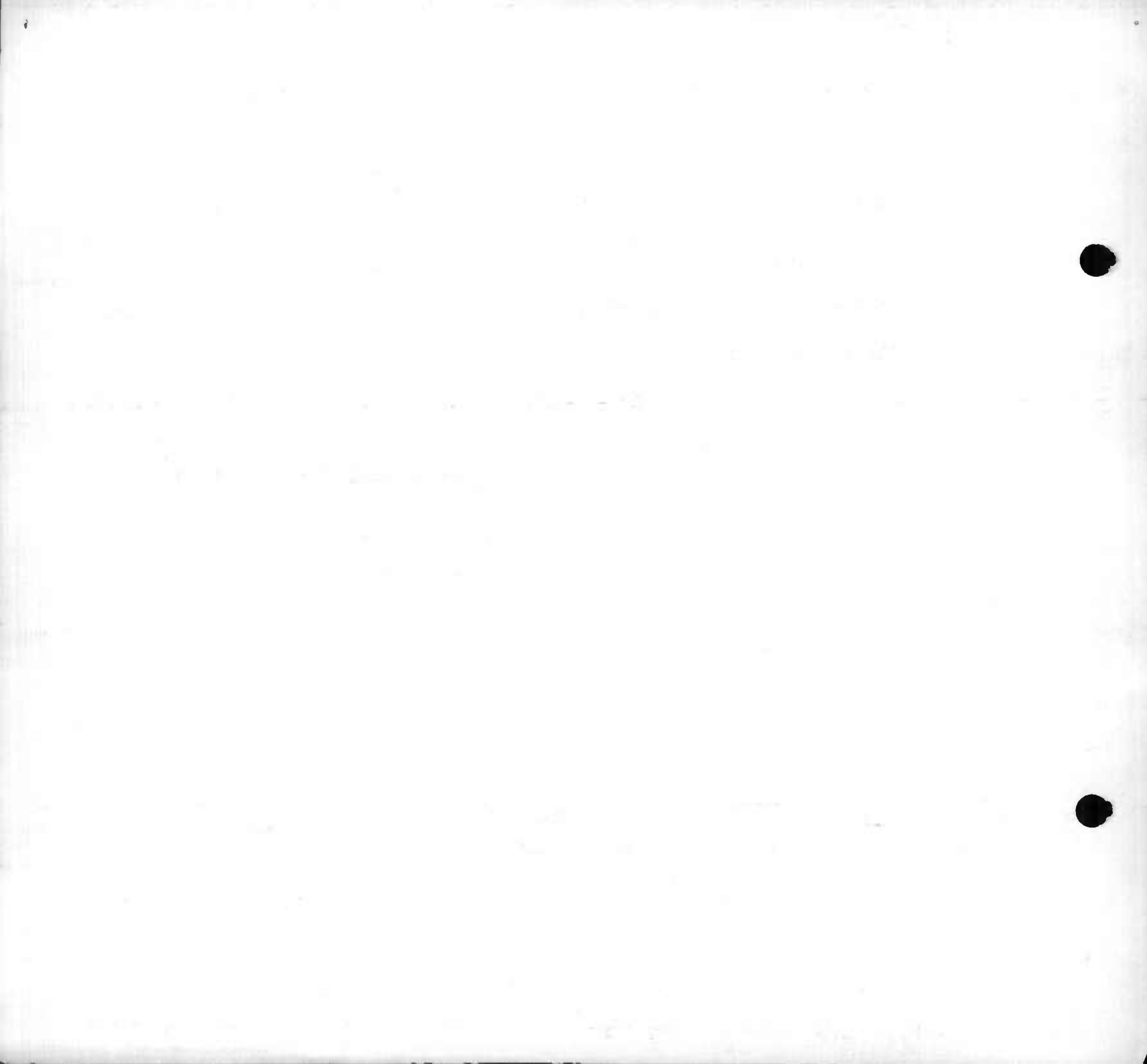
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7609	
W-220 70 7609		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) FRANK WASKIEWICZ		2. DATE AND HOUR OF DEATH 8-1-70 7:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD NORTH CHARLES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 0102	
FULL NAME OF HOSPITAL OR INSTITUTION 49 NORTH CHARLES HOSPITAL		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 626 S. Curley Street #21224 8724 NORTH CHARLES ST.	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-93
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY RETIRED FROM MARYLAND DRY DOCK	9. AGE (In years last birthday) (77) 76
13. FATHER'S NAME Frank Waskiewicz		11. BIRTHPLACE (State or foreign country) GERMANY - Poland	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
16. SOCIAL SECURITY NO. 217-07-6181		17. INFORMANT Chester Bujanowski - 626 S. Curley St.	
18. CAUSE OF DEATH 470.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Post Cholecystectomy for Cholecystitis & cholelithiasis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 days	
19A. DATE OF OPERATION 17-29-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystitis & cholelithiasis	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 14 1970 to AUGUST 1 1970 that (I) (we) last saw the deceased alive on AUG. 1 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Arthur P. Pangilinan, M.D.		23B. DATE SIGNED 8-1-70	
23C. PHYSICIAN'S NAME (Type) Arthur P. Pangilinan M.D.		23D. ADDRESS 2724 N. Charles Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/70	
24C. NAME OF CEMETERY OR CREMATORY U. S. National - Loudon Pk.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.A.	
25C. FUNERAL DIRECTOR George A. Weber - 705 S. Ann St. #21231		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

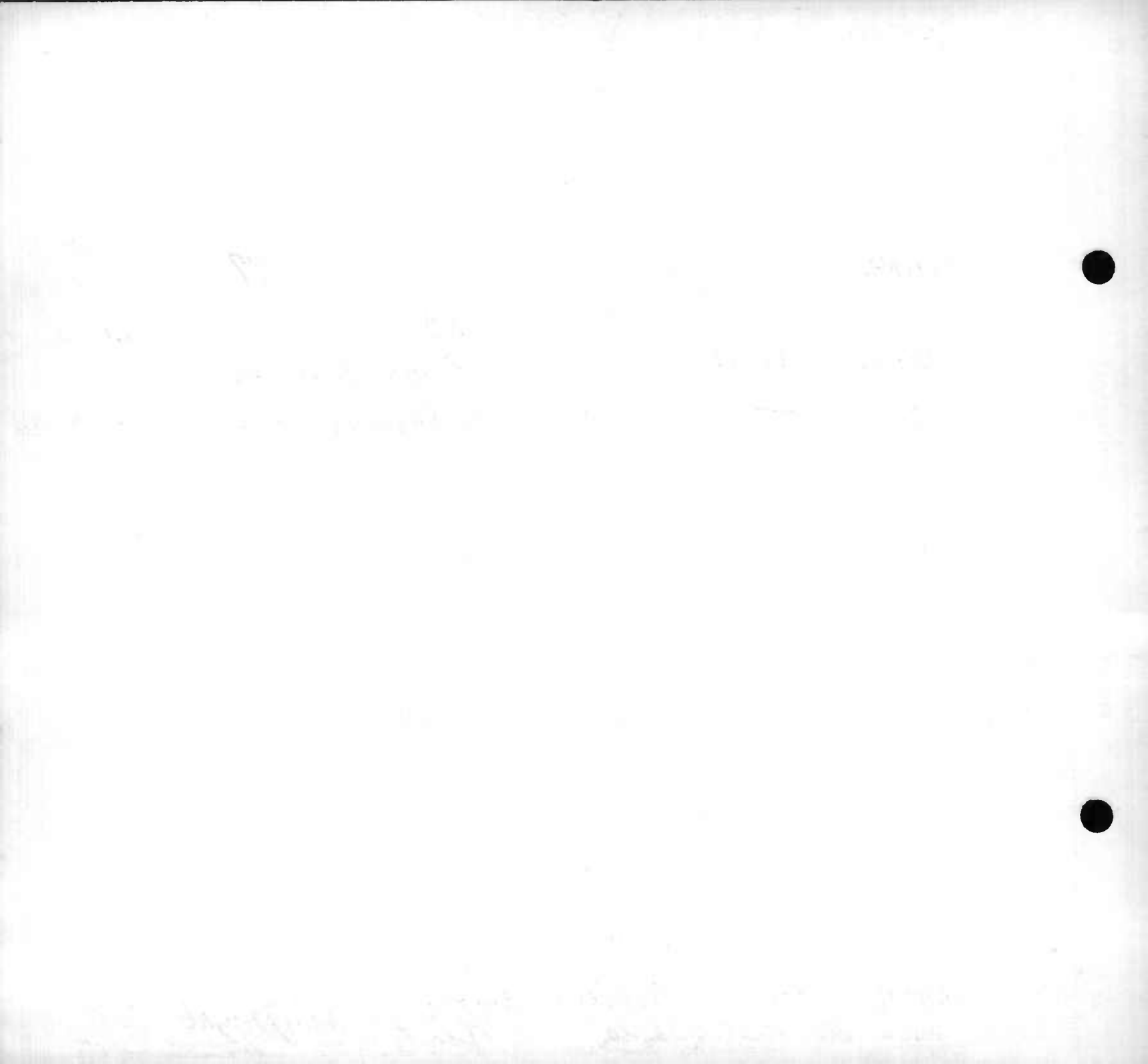
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 7610	
B-200 70 7610		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) NORMAN BAGE		2. DATE AND HOUR OF DEATH 7-29-70 4⁰⁵ P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER #3 DREHER AVE			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-21-42	9. AGE (In years last birthday) 28
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10B. KIND OF BUSINESS OR INDUSTRY Price Printing		11. BIRTHPLACE (State or foreign country) W. Virginia	
13. FATHER'S NAME William Dennis Bage		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-38-5129		17. INFORMANT Mrs. Mary A. Bage #3 Dreker Avenue 21208	
18. 347.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF: CEREBRAL ANOXIA SEIZURE & ASPIRATION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-21 19 70 to 7-29 19 70 that (I) (last) last saw the deceased alive on 7-29 19 70 and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE Ralph Epstein MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-29-70	
23C. PHYSICIAN'S NAME (Type) RALPH EPSTEIN MD		23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/3/70		24C. NAME of CEMETERY or CREMATORY Lake View Memorial Park	
24D. LOCATION (City, town, or county) (State) Sykesville Carroll Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970			
25B. NAME OF REGISTRAR Robert E. Taylor R.D.		25C. FUNERAL DIRECTOR Loring Byers 8728 Liberty Road 21133			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-500 70 7611		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 70 7611	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BELLE PENN		2. DATE AND HOUR OF DEATH 7/30/70 9:15A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALT.		C. CITY OR TOWN CHESAPEAKE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION NORTH CHARLES GEN HOSP		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 49		E. STREET AND NUMBER 315 England Ave.	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/31/92	9. AGE (In years last birthday) 78	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME VELARIUS PENN		14. MOTHER'S MAIDEN NAME Annie Richark	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT MR. Raymond Jackson	
18. 4/2/31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Gangrene of Rt leg (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Embolism of leg (B) DUE TO, OR AS A CONSEQUENCE OF: Coroniosclerotic Heart Disease (C) —		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Days years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nearly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/27/70 to 7/30/70 and that (I) (we) last saw the deceased alive on 7/30/70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Manlio V. Patricio		23B. DATE SIGNED 7/30/70		23C. PHYSICIAN'S NAME (Type) Manlio V. PATRICIO	
23D. ADDRESS NORTH CHARLES GEN HOSP.		23E. FUNERAL DIRECTOR Harry Haight		23F. ADDRESS —	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-1-70		24C. NAME OF CEMETERY OR CREMATORY Providence Cemetery	
24D. LOCATION Glenelg Md.		24E. DATE REC'D BY HEALTH DEPT. AUG 3 1970		24F. NAME OF REGISTRAR Robert E. Taylor, Jr.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 7612

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Robert L. Killins

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

4405 Groveland Avenue

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

July 28, 1970

12:40 P.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

2841

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

11/23/1950

10. AGE (in years
last birthday)

19

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

4405 Groveland Avenue

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Leroy Killins

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Catherine King

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Leroy Killins 4405 Groveland Avenue

19.

304.91

CAUSE OF DEATH

Intravenous narcotism

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/29/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/31/1970

24C. NAME OF CEMETERY or CREMATORY

Baltimore National Cem

24D. LOCATION (City, town, or county)

Baltimore

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 3 1970

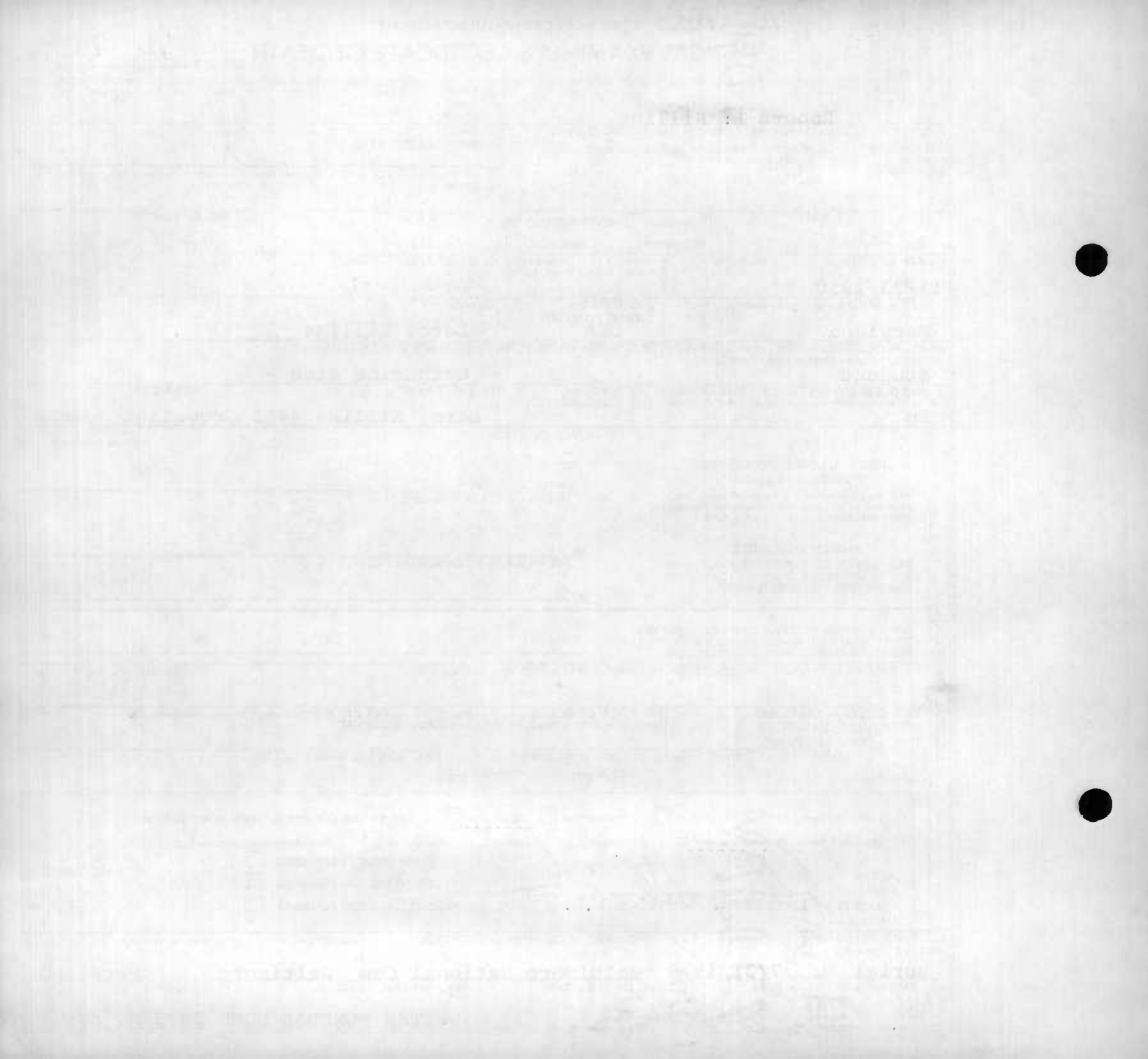
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

NUTTER FUNERAL HOME 3035 W. NORTH AV



1

70 7613

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 7613

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Mabel Isabelle		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 30 70 2:20 a M.	
6. SEX female		7. RACE colored	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 6/24/1902		10. AGE (In years lost birthday) 68	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY Home	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Mabel Bennett		18. INFORMANT Mr. Alexander Isabelle	
19. 4/24/70 CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____	
20A. DATE OF OPERATION 7/31/70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		DATE SIGNED 7/31/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/4/1970	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore County Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH AV	

10-1-1970

RECEIVED
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OCT 1 1970

10-1-1970

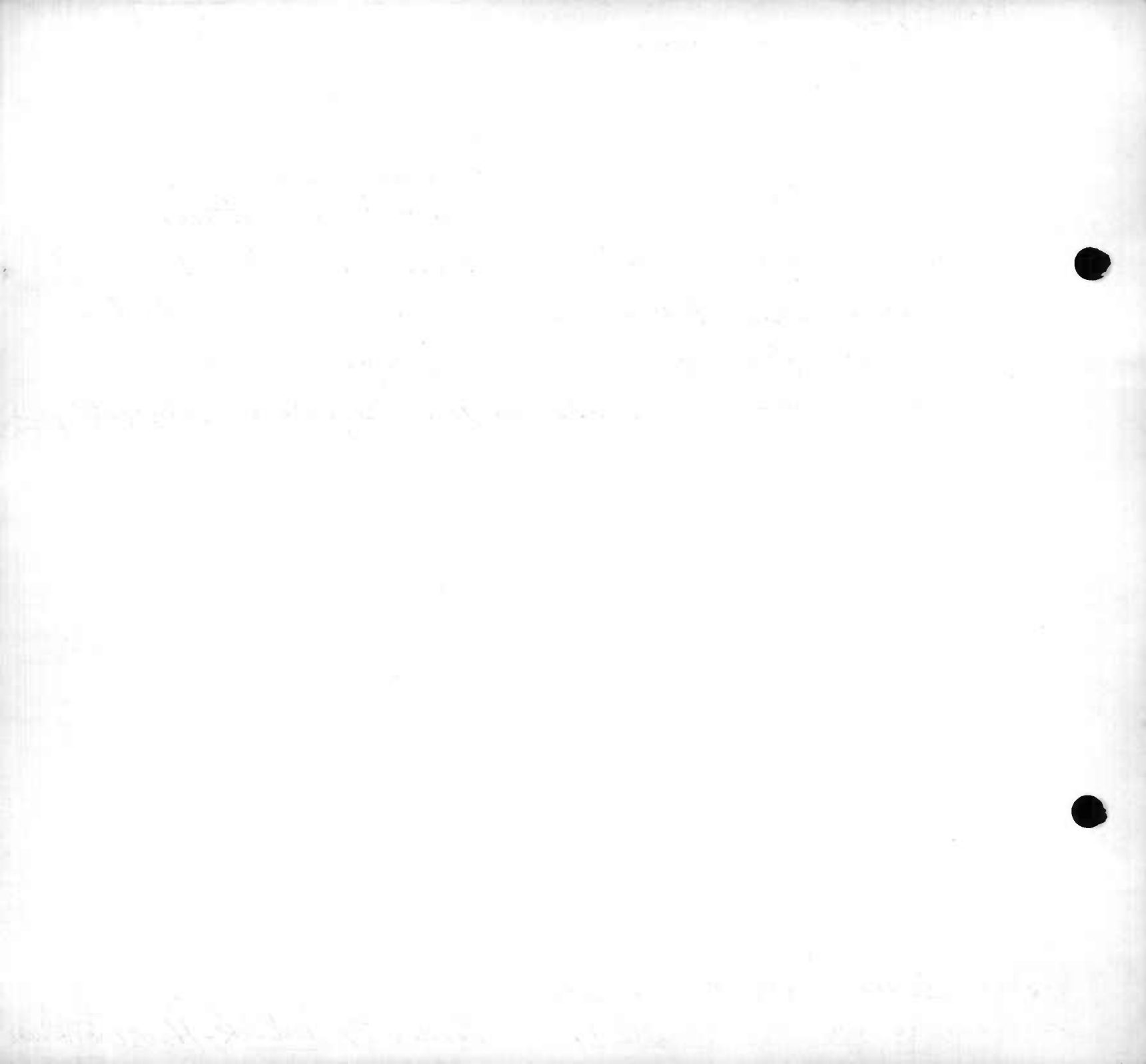
10-1-1970

10-1-1970

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

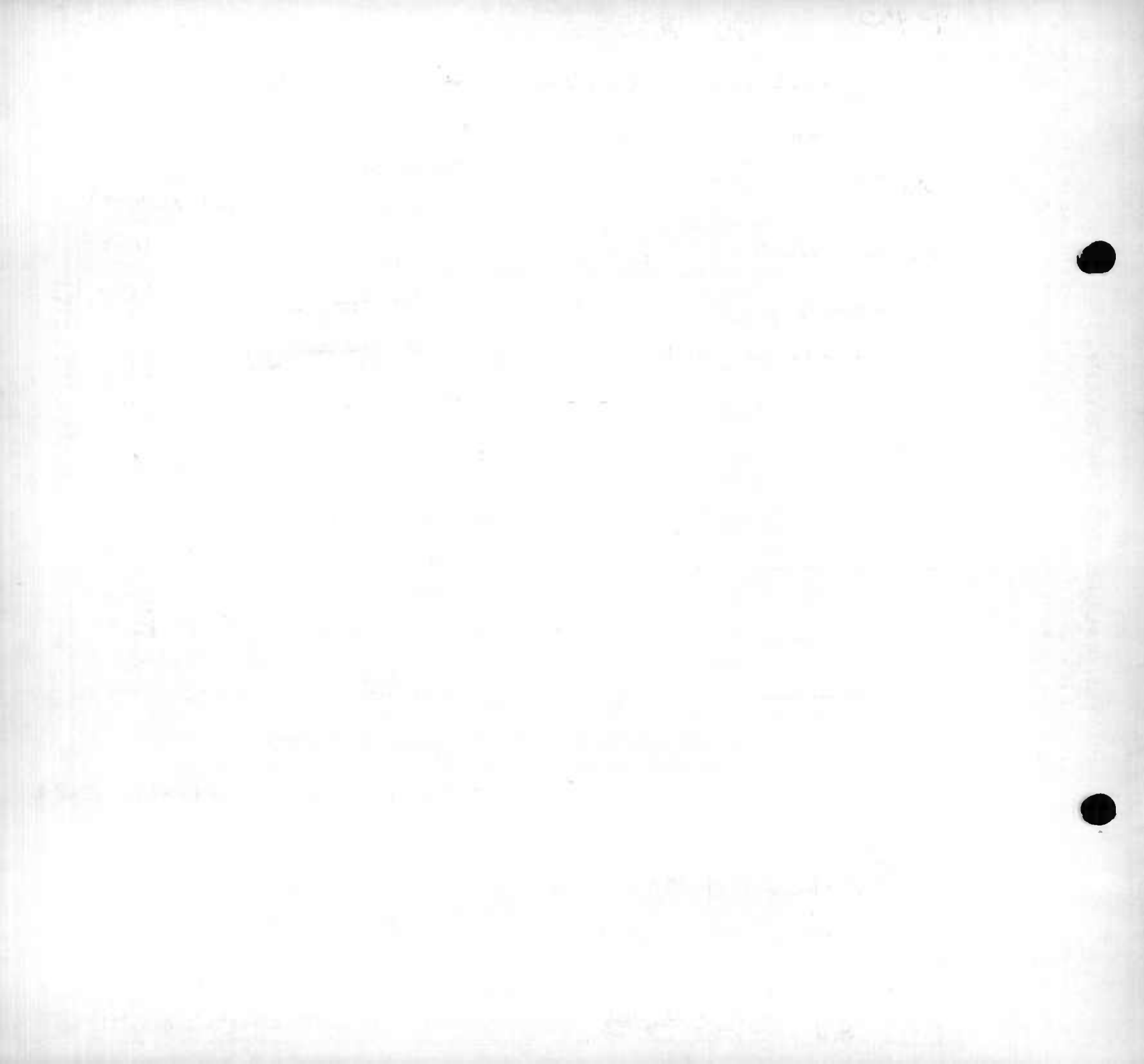
R-236		70 7614		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 7614	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>JENNIE MYRTLE</i> <i>RECTOR</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <i>7-25-70</i> <i>9¹⁵ A. M.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>37</i> <i>Mercy</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Cecil</i>		C. CITY OR TOWN <i>Port Deposit</i>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>238 N. Main Street</i>	
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 25, 1901</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months: <i>3</i> Days: <i>3</i>	If Under 24 Hrs. Hours: <i>3</i> Min. <i>15</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia - U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>No Record</i>		14. MOTHER'S MAIDEN NAME <i>Rosa Carter</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <i>No</i>			
		16. SOCIAL SECURITY NO. <i>231-36-8534</i>		17. INFORMANT <i>Mrs. Elizabeth M. Boddy - Port Deposit</i>			
18. <i>412.31</i>		CAUSE OF DEATH		ADDRESS			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE <i>Uremia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>18 days</i>			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES		(B) <i>C. V. A with Right Hemiplegia</i>		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <i>A. S. H. D with Atrial Fibrillation</i>		DUE TO, OR AS A CONSEQUENCE OF:			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>7/17</i> 19 <i>70</i> to <i>7/25</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>7/25</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Borrem Kim</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7/25/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>BOO KEUN KIM</i>				23D. ADDRESS <i>MERCY HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-28-70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Baptist Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Culpeper, Va.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 3 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Elmer E. Bullock - House of David</i>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-553 BIRTH NO. 70 7615		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X Registered No. 70 7615	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) VOLLAND, ELIZABETH		2. DATE AND HOUR OF DEATH 7/29/1970 1150 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Mayland General Hospital.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3526 Milford Mill Rd.			
5. SEX Female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 5/25/1892	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Fredrick Hitz		14. MOTHER'S MAIDEN NAME Elizabeth Von Kepper	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-09-5275		17. INFORMANT ADDRESS Louis W. Volland 5806 Berkley Avenue	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest.		CAUSE OF DEATH (A) DUE TO Cardiac Arrest. (B) DUE TO Myocardial Infarction?? (C) DUE TO AscVD.		INTERVAL BETWEEN ONSET AND DEATH 8 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. possibly malignant disease of the heart.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/22/1970 to 7/29/1970 , that (I) (we) lost saw the deceased alive on 7/29/1970 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mohamed S. Al-Ibrahim M.D.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) M.S. AL-IBRAHIM M.D.	
23D. ADDRESS MD. Gen. Hospital.		23E. FUNERAL DIRECTOR ADDRESS Loring Byers 8728 Liberty Road 21133		23F. NAME OF REGISTRAR Robert E. Taylor	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/3/70		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) Baltimore Maryland		24E. STATE (State) Maryland		24F. DATE REC'D BY HEALTH DEPT. AUG 3 1970	



1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH		10. AGE (In years lost birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
John O'Connell		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour		University Hospital		Delaware		male		white				3/10/26		44		Delaware		USA		John J. O'Connell, Sr.		Truck Driver		Susan P. ?		No									
				Month Day Year Hour				A. STATE B. COUNTY																															
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UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE ASSISTANT SECRETARY FOR TECHNICAL ASSISTANCE

WASHINGTON, D. C. 20250

January 1, 1964

Mr. J. H. ...

Dear Sir:

I am pleased to hear that you are interested in the

work of the Office of the Assistant Secretary for Technical Assistance

and that you are considering the possibility of

cooperating with us in the future.

I am sure that your interest in the work of the Office

will be well served by the information which I am

now sending you.

I am, Sir, very respectfully,

Yours very truly,

Assistant Secretary for Technical Assistance

Enclosure

Very truly yours,

John A. ...

Assistant Secretary for Technical Assistance

Enclosure

Very truly yours,

John A. ...

Assistant Secretary for Technical Assistance

Enclosure

Very truly yours,

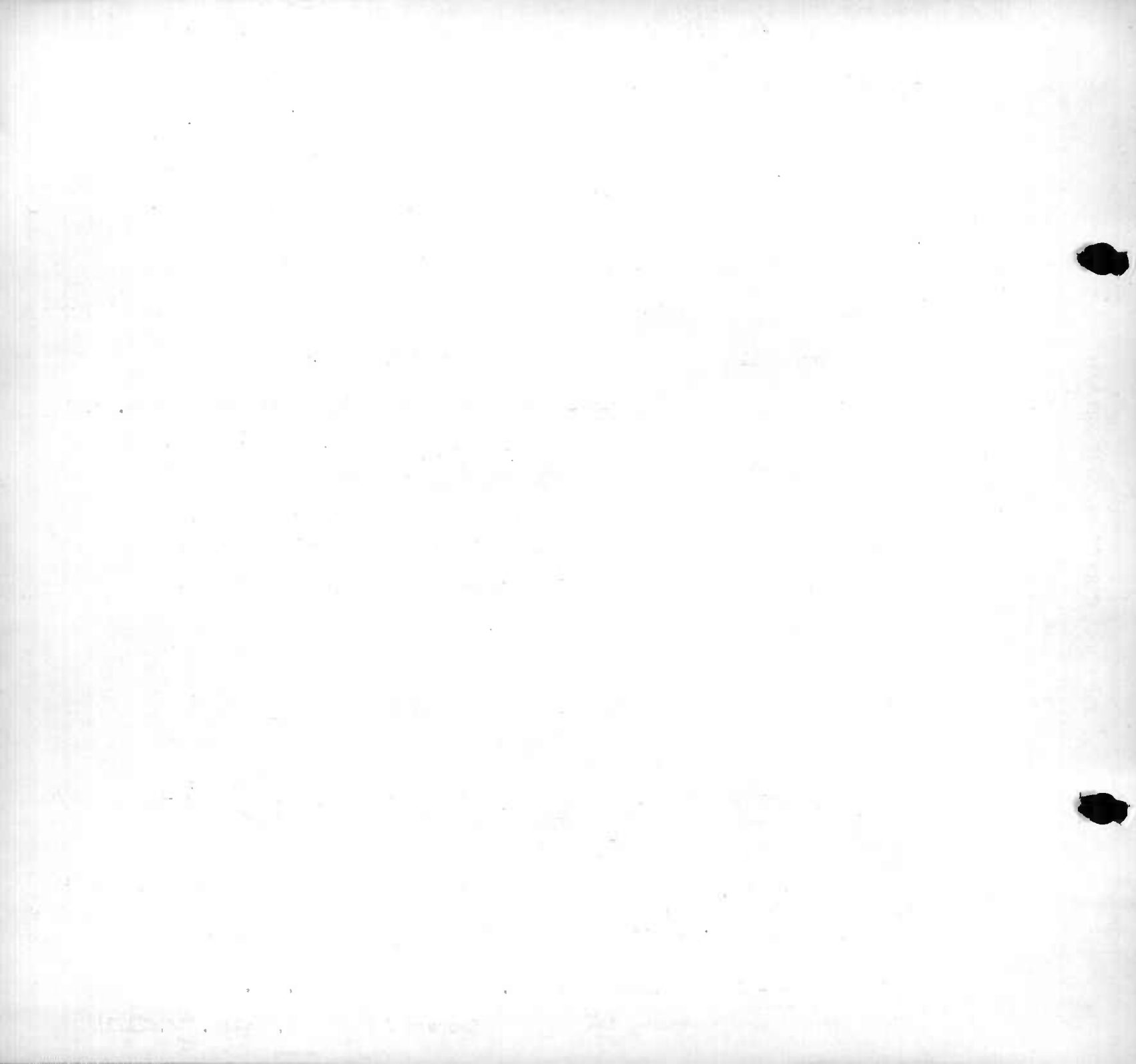
John A. ...

Assistant Secretary for Technical Assistance

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

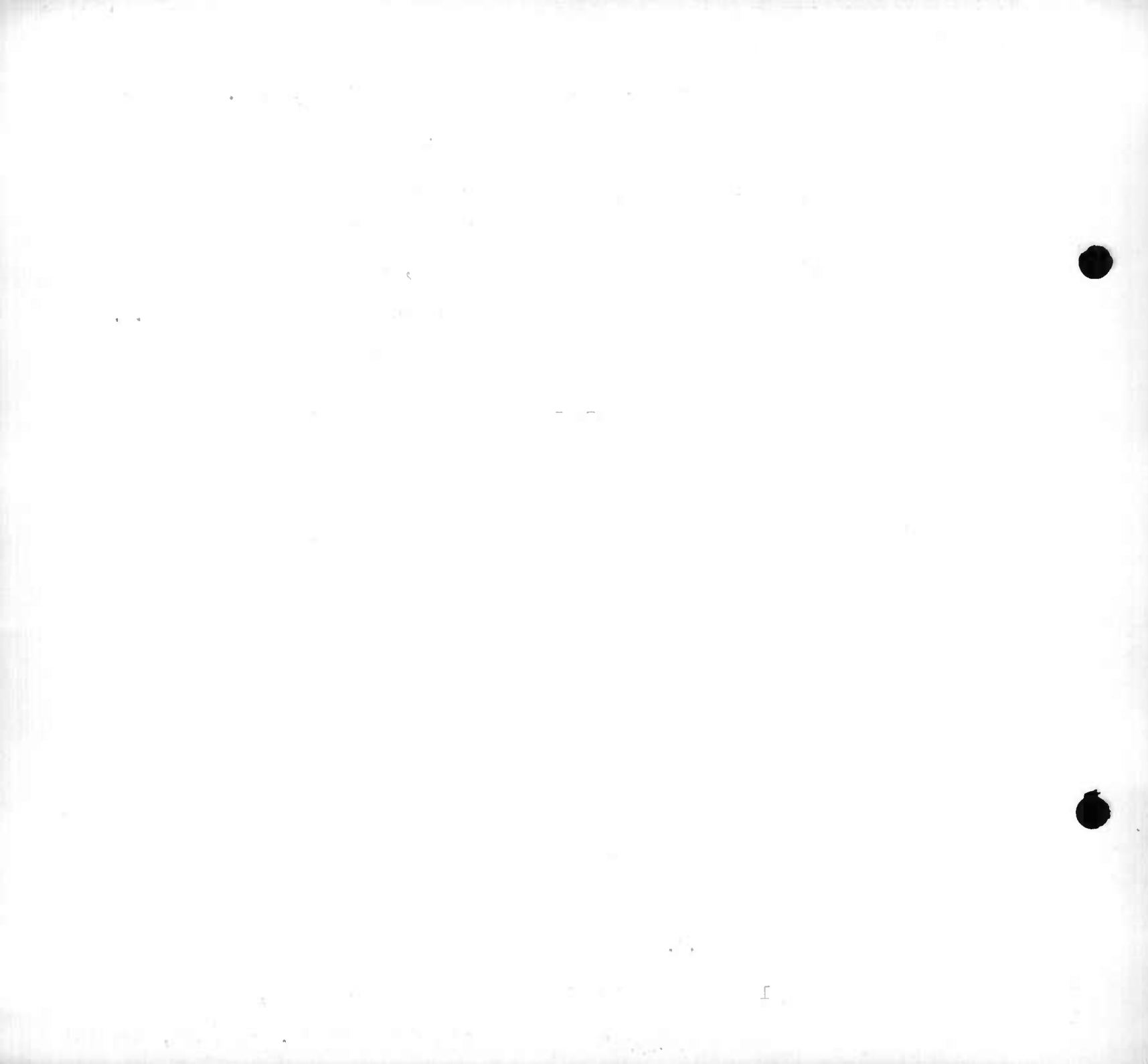
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7617	
M-460 70 7617		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Ellsworth HARRY E. MILLER		2. DATE AND HOUR OF DEATH 7/31/70 1:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) GOULD CONVALESCENTIUM		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 2744			
5. SEX M 6. RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 21 1881	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGR		10B. KIND OF BUSINESS OR INDUSTRY BALTO TRANS IT		9. AGE (In years lost birthday) 88	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA, USA			
13. FATHER'S NAME Charles Henry Miller		14. MOTHER'S MAIDEN NAME Isabella Briscoe			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-9869		17. INFORMANT ADDRESS Mrs Grace E White 4629 Walther Ave. 21214	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 4/23/185X		CAUSE OF DEATH Arteriosclerotic Heart Disease (A) IMMEDIATE CAUSE Myocardial Infarction DUE TO OR AS A CONSEQUENCE OF: Carcinoma of Prostate (B) DISEASE OR CONDITION WHICH WAS A CONSEQUENCE OF: Chronic Arteriosclerosis (C) Gen. Arteriosclerosis			
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1 1965 to July 31 1970 , that (I) (we) last saw the deceased alive on July 29 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald W. Mintzer		23B. DATE SIGNED July 31/1970		23C. PHYSICIAN'S NAME (Type) DONALD W. MINTZER	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-4-70		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Leonard J Ruck Inc. Balto. Md. 21214		25D. ADDRESS 3009 EVERGREEN AVE BALTO MD 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7618	
D-260		70 7618		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Joseph L. Dacre		July 29, 1970. 3:08 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital			A. STATE Maryland		
			B. COUNTY 2631		
C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 5765 White Ave					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 18, 1920	9. AGE (in years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Vincent Dacre		14. MOTHER'S MAIDEN NAME Eleanor Ironia	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11		16. SOCIAL SECURITY NO. 218-07-2304		17. INFORMANT Mrs Zelpha M Dacre	
				ADDRESS Same	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiopulmonary arrest</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial infarction</i> (C) <i>ASCVD</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 13 th hr 7/29 1970 to 3 rd hr 7/29 1970 that (I) (we) last saw the deceased alive on 7/29 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Harvey G. Klein</i>		23B. DATE SIGNED 7/29/70		23C. PHYSICIAN'S NAME (Type) Harvey G Klein M.D.	
23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/3/70		24C. NAME of CEMETERY or CREMATORY Parkwood	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Faber, M.D.		25C. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland	



FUNERAL DIRECTOR: IMPORTANT

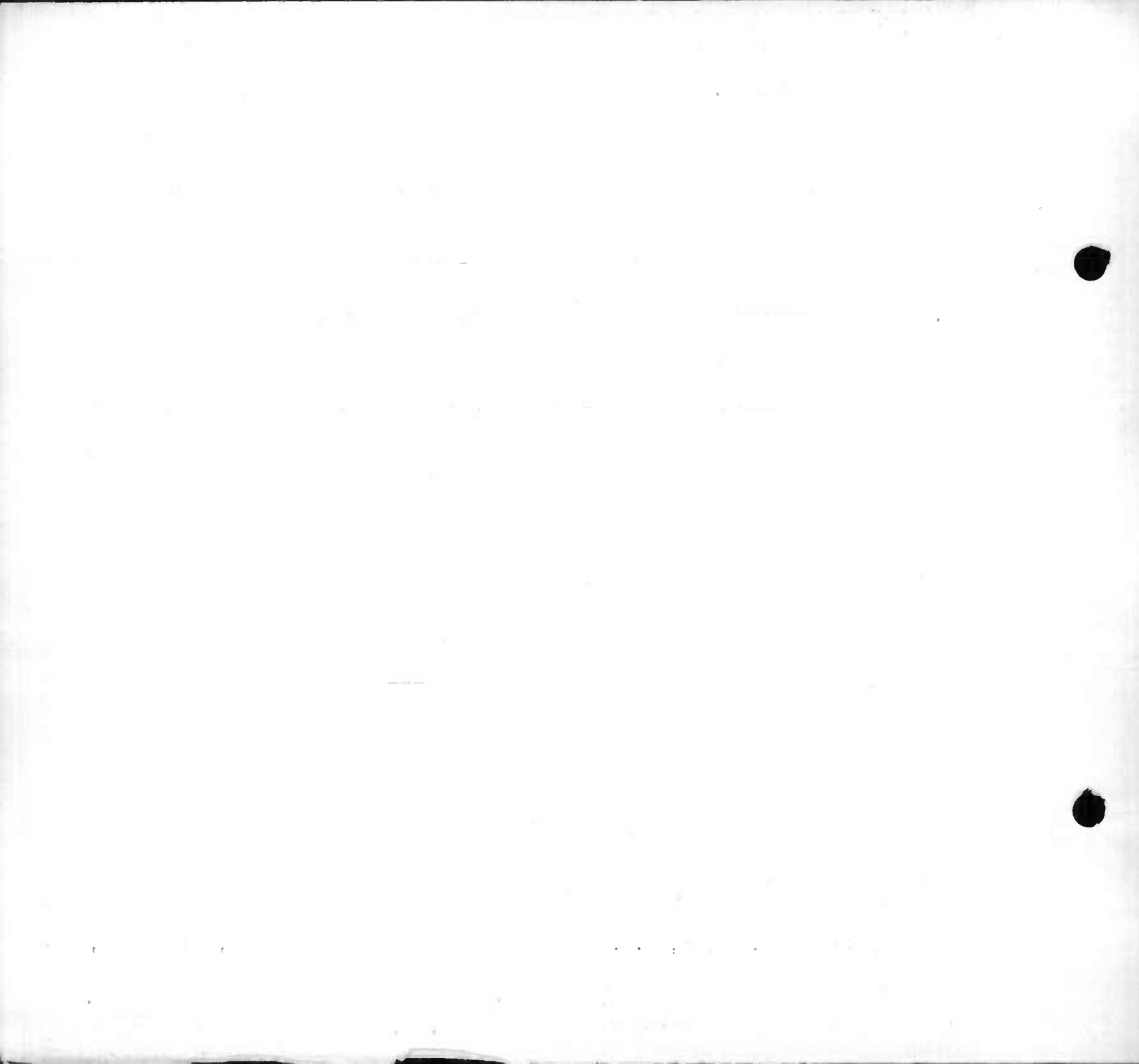
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7619	
F-460		70 7619		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Elizabeth B Fowler		2. DATE AND HOUR OF DEATH July 30, 1970 9:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Convalesarium		A. STATE Maryland		C. CITY OR TOWN Baltimore	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 3106 Juneau Place	
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH June 12, 1892	10. AGE (In years last birthday) 78	11. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME William Bell		14. MOTHER'S MAIDEN NAME Henrietta Reese		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-28-3915		17. INFORMANT Mrs Millicent B Mauldin	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.41 (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Anterograde C-V disease associated Atrial fibrillation		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO OR AS A CONSEQUENCE OF: Chronic myocarditis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Dehydration			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from May 3 1970 to July 30 1970 , that (1) (we) last saw the deceased alive on July 30 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE N.V. Harbold M.D.		23B. DATE SIGNED July 30, 1970		23C. PHYSICIAN'S NAME (Type) N.V. HARBOLD M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/1/70		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. ADDRESS 4706 Nayford Road		24F. STATE Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.S.		25C. FUNERAL DIRECTOR Leonard J Ruck Inc.	
ADDRESS Baltimore, Maryland					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

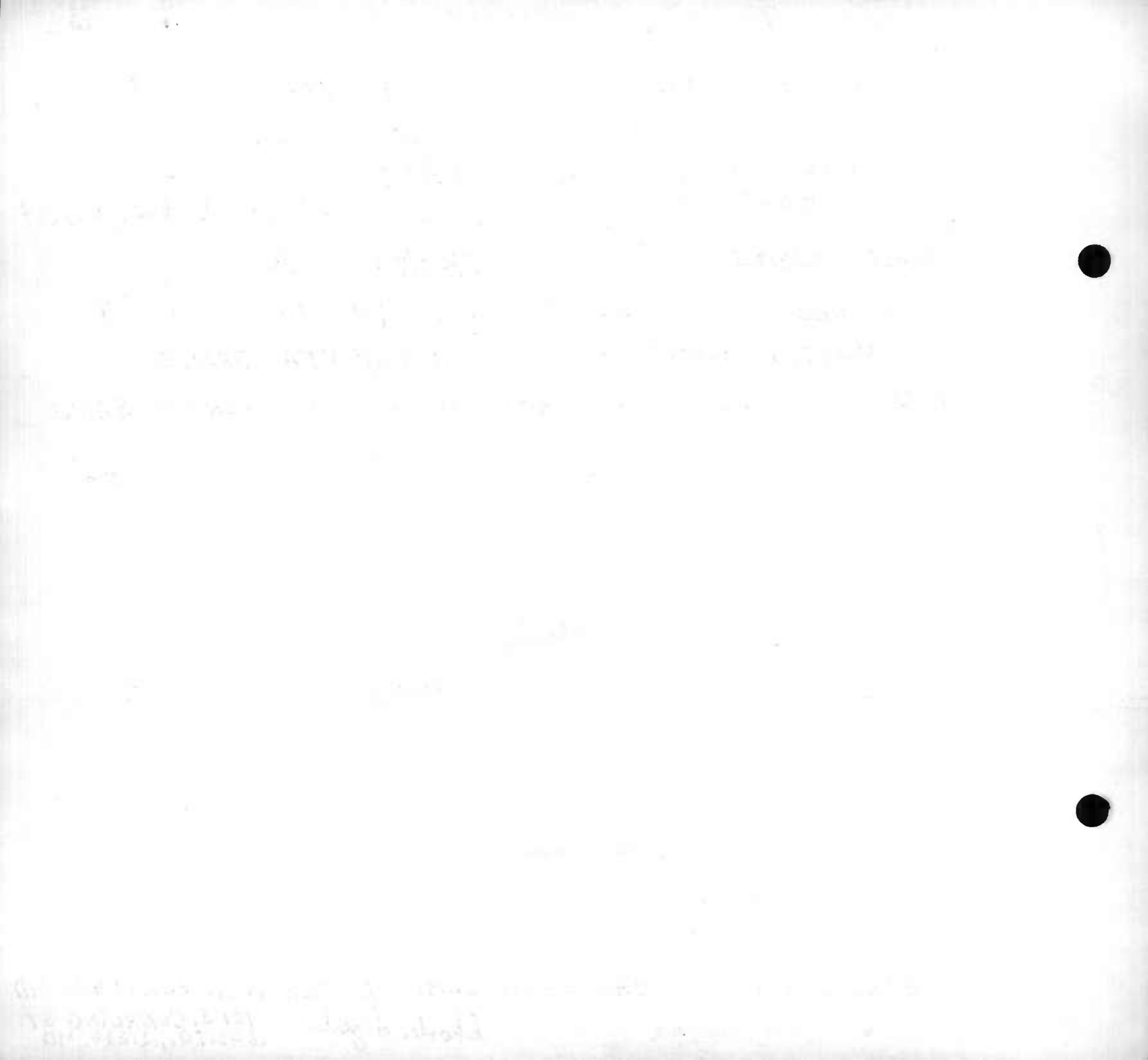
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7620</u>	
<div style="display: flex; justify-content: space-between;"> <u>G-320</u> <u>70 7620</u> CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Estella M. Goetze</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>26 July 1970,</u> <u>5P</u> M.			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>City</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-24-84</u> 9. AGE (In years last birthday) <u>86</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto Co.</u>	
13. FATHER'S NAME <u>Richard Fitzell</u>		14. MOTHER'S MAIDEN NAME <u>Anna ?</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Daughter</u> ADDRESS <u>Same</u>	
18. <u>486X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<u>None</u>			
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6 July</u> 19 <u>70</u> to <u>26 July</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>5 PM 26 July</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Herbert B. Allen, M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>26 July 1970</u>	
23C. PHYSICIAN'S NAME (Type) <u>Herbert B. Allen, M.D.</u>		23D. ADDRESS <u>Johns Hopkins Hospital, Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/29/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Immanuel Cem.</u>	
24D. LOCATION <u>Grindon Lane</u>		24E. BALTO. <u>Balto.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 3 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>P. A. Heemann</u> ADDRESS <u>6067 Harford Rd.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO.
S-260 70 7621		40-22-18 107 670 7621		
1. NAME OF DECEASED (Type or Print) LOUIS SCHWEIGER		2. DATE AND HOUR OF DEATH 7/25/70. 4:45 AM - EDT M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNIV. MARY. HOSP.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARY - B. COUNTY 2609		
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSP. OF MD. BALTO., MD.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY STEVEDORE		8. DATE OF BIRTH 7/24/90
13. FATHER'S NAME MARTIN SCHWEIGER		14. MOTHER'S MAIDEN NAME HENRIETTA BRANZ		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-03-3435A		9. AGE (In years last birthday) 80
17. INFORMANT CAROLINE SCHWEIGER		ADDRESS SAME		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 4/12/31		CAUSE OF DEATH Irreversibly Congestive Heart Failure		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Emboli to legs + BPH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 7/12 19 70 to 7/24 19 70 that (I) (we) last saw the deceased alive on 7/24 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.				
23A. SIGNATURE Michael A. Chasin M.D.		23B. DATE SIGNED 7/25/70		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) Michael A. Chasin		23D. ADDRESS UNIV. MARY. HOSP - BALTO. MARY		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-28-70		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.
24D. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD., BALCO, MD.		25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Charles J. Geller		
25D. ADDRESS 901 S. CONKLING ST. BALTO., 21224, MD.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70-13776		70 7622		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 7622			
1. NAME OF DECEASED (Type or Print) SMITH, BOY, NANCY					2. DATE AND HOUR OF DEATH 7/22/70 6:14 AM						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY St. Marys 6800						
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITALS 21224 940 Eastern Avenue, Baltimore, Maryland					C. CITY OR TOWN Leonardtown		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
					E. STREET AND NUMBER P.O. 20650						
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-22-1970	9. AGE (in years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James R.					14. MOTHER'S MAIDEN NAME Nancy <i>cliff Davidson</i> 1968						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224					
18. <i>759.9 I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					(A) IMMEDIATE CAUSE <i>NEONATAL RESPIRATORY DEPRESSION</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>MULTIPLE CONGENITAL MALFORMATION</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>7</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nailly medical examined)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (H) (this hospital) attended the deceased from <i>7/22/70</i> 19 to <i>7/22/70</i> 19 that (H) (we) last saw the deceased alive on <i>7/22/70</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Suehakorn A. Amrung, M.D.</i>					23B. DATE SIGNED 7/22/70			23C. PHYSICIAN'S NAME (Type) DR. S. AMRUNG			
23D. ADDRESS BALTIMORE CITY HOSPS. 4940 Eastern Avenue, Baltimore, Maryland 21224					23E. DATE REC'D BY HEALTH DEPT. AUG 3 1970						
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation					24B. DATE 7-23-70		24C. NAME of CEMETERY or CREMATORY Baltimore City Hospitals		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224		
25A. NAME OF REGISTRAR Robert E. Taylor, R.D.					25B. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD						



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p style="font-size: 24pt; margin: 0;">L.000 70 7623</p> <p style="font-size: 18pt; margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</p>		<p style="font-size: 24pt; margin: 0;">70 7623</p> <p style="font-size: 18pt; margin: 0;">REG. NO.</p>	
<p style="font-size: 24pt; margin: 0;">BIRTH NO. PAY FOO LEE/HOY K.KEG</p> <p style="font-size: 24pt; margin: 0;">CERTIFICATE OF DEATH</p>			
<p>1. NAME OF DECEASED (Type or Print)</p> <p style="font-size: 24pt; text-align: center;">LEE Pay</p>		<p>2. DATE AND HOUR OF DEATH</p> <p style="font-size: 24pt; text-align: center;">7/29/70 11:40 p.m.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p style="font-size: 24pt; text-align: center;">Sinner Hospital of Baltimore</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE B. COUNTY</p> <p style="font-size: 24pt; text-align: center;">Md. 2831</p>	
<p>5. SEX</p> <p style="font-size: 24pt; text-align: center;">male</p>		<p>6. RACE</p> <p style="font-size: 24pt; text-align: center;">oriental</p>	
<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/></p> <p>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH</p> <p style="font-size: 24pt; text-align: center;">7/3/90</p>	
<p>9. AGE (In years lost birthday)</p> <p style="font-size: 24pt; text-align: center;">80</p>		<p>10. CITIZEN OF WHAT COUNTRY</p> <p style="font-size: 24pt; text-align: center;">? Hong-Kong</p>	
<p>11. BIRTHPLACE (State or foreign country)</p> <p style="font-size: 24pt; text-align: center;">Probably China</p>		<p>12. CITIZEN OF WHAT COUNTRY</p> <p style="font-size: 24pt; text-align: center;">? Hong-Kong</p>	
<p>13. FATHER'S NAME</p> <p style="font-size: 24pt; text-align: center;">Unknown</p>		<p>14. MOTHER'S MAIDEN NAME</p> <p style="font-size: 24pt; text-align: center;">Unknown</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p style="font-size: 24pt; text-align: center;">doubtful</p>		<p>16. SOCIAL SECURITY NO.</p> <p style="font-size: 24pt; text-align: center;">217-01-4380A</p>	
<p>17. INFORMANT</p> <p style="font-size: 24pt; text-align: center;">Belvedere Nursing Home Records</p>		<p>18. CAUSE OF DEATH</p> <p style="font-size: 24pt; text-align: center;">Pulmonary embolism</p>	
<p>19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="font-size: 24pt; text-align: center;">Chronic Arteriosclerotic vascular disease</p>		<p>20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p style="font-size: 24pt; text-align: center;">1/4 hour</p>	
<p>21. ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last</p> <p style="font-size: 24pt; text-align: center;">Upper G.I. bleeding</p>		<p>22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p style="font-size: 24pt; text-align: center;">1 day</p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> <p style="font-size: 24pt; text-align: center;">Upper G.I. bleeding</p>			
<p>19A. DATE OF OPERATION</p> <p style="font-size: 24pt; text-align: center;">7/28/70</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p style="font-size: 24pt; text-align: center;">Bilio-femoral embolism</p>	
<p>20A. AUTOPSY? (Yes or No)</p> <p style="font-size: 24pt; text-align: center;">No</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> <p style="font-size: 24pt; text-align: center;">No</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> <p style="font-size: 24pt; text-align: center;">No</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p style="font-size: 24pt; text-align: center;">No</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> <p style="font-size: 24pt; text-align: center;">No</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p> <p style="font-size: 24pt; text-align: center;">No</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> <p style="font-size: 24pt; text-align: center;">No</p>		<p>21F. HOW DID INJURY OCCUR?</p> <p style="font-size: 24pt; text-align: center;">No</p>	
<p>22. I certify that (this hospital) attended the deceased from 7/27 1970 to 7/29 1970 that (we) last saw the deceased alive on 7/29 1970 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE</p> <p style="font-size: 24pt; text-align: center;">Leveque</p>		<p>23B. DATE SIGNED</p> <p style="font-size: 24pt; text-align: center;">7/29/70</p>	
<p>23C. PHYSICIAN'S NAME (Type)</p> <p style="font-size: 24pt; text-align: center;">LEVEQUE M.D.</p>		<p>23D. ADDRESS</p> <p style="font-size: 24pt; text-align: center;">Sinner Hospital of Baltimore</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p style="font-size: 24pt; text-align: center;">Burial</p>		<p>24B. DATE</p> <p style="font-size: 24pt; text-align: center;">8/4/70</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY</p> <p style="font-size: 24pt; text-align: center;">Lorraine Park Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State)</p> <p style="font-size: 24pt; text-align: center;">Woodlawn, Balto. Co., Md.</p>	
<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p style="font-size: 24pt; text-align: center;">AUG 3 1970</p>		<p>25B. NAME OF REGISTRAR</p> <p style="font-size: 24pt; text-align: center;">Robert E. Farley, M.D.</p>	
<p>25C. FUNERAL DIRECTOR</p> <p style="font-size: 24pt; text-align: center;">STEWART & MOWEN CO.</p>		<p>25D. ADDRESS</p> <p style="font-size: 24pt; text-align: center;">108 W. North Av. (1)</p>	

V.S. 153

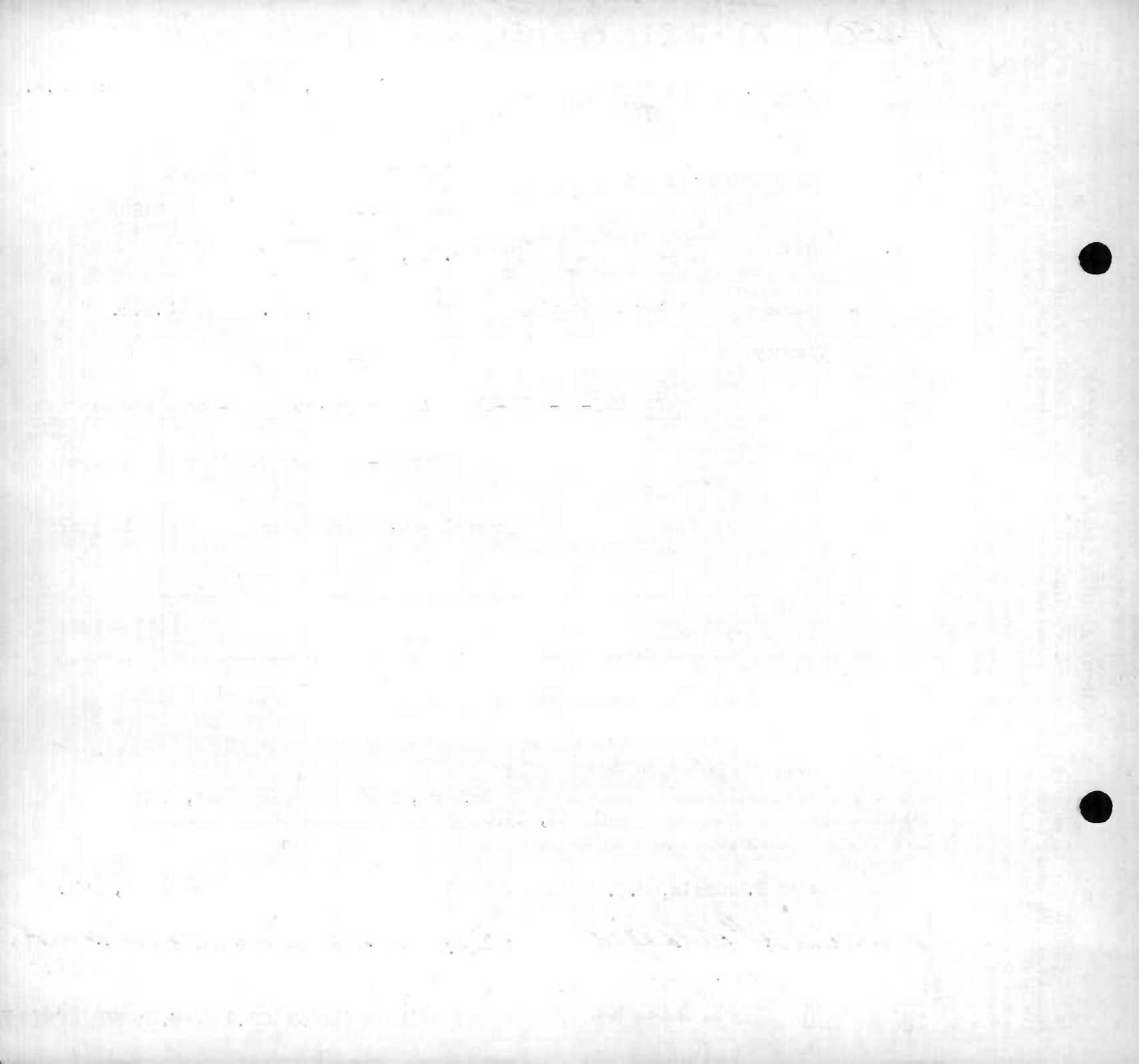
8-7-70

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

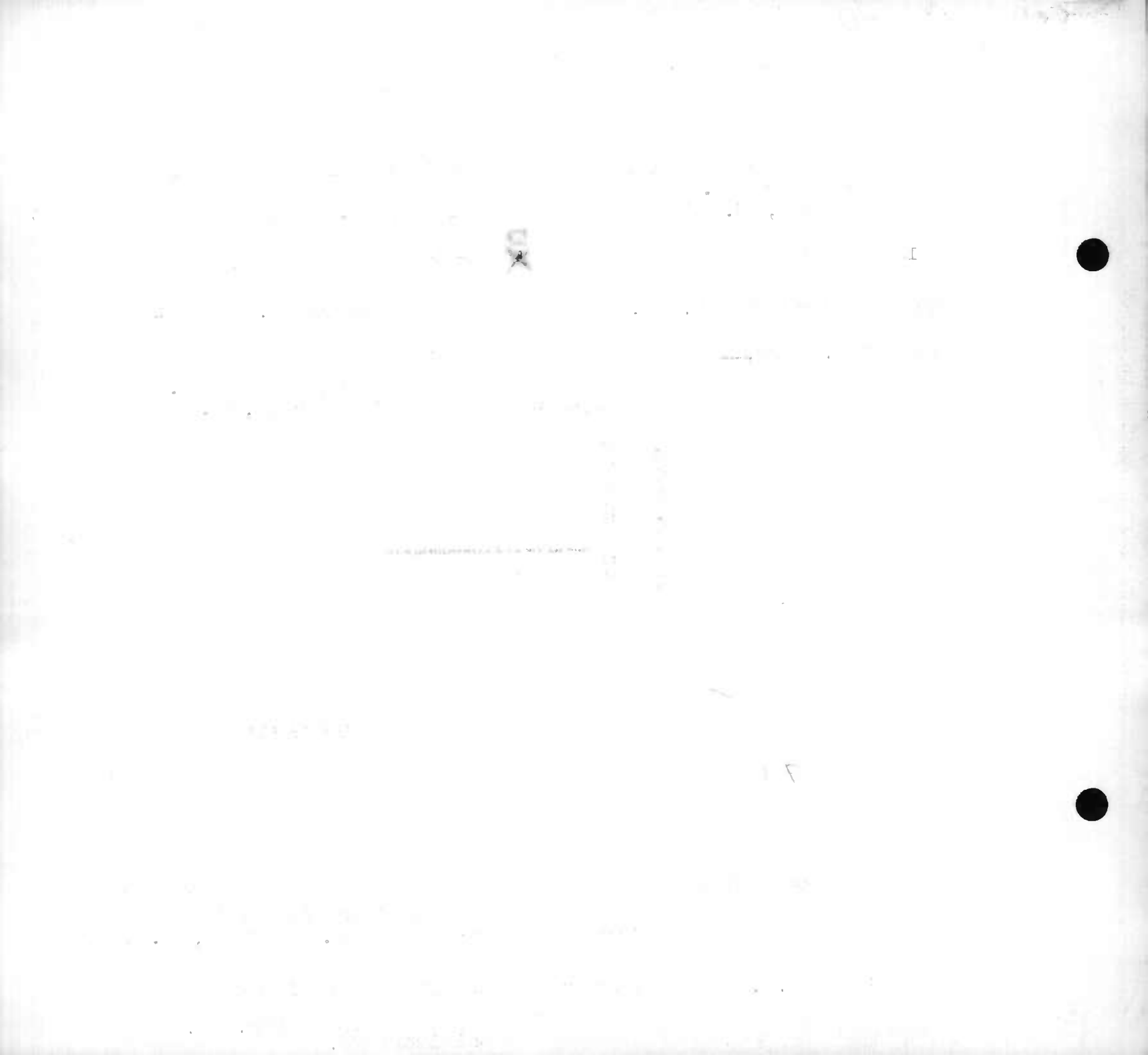
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7624	
T-650 70 7624		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) Sister Louise Tierney			2. DATE AND HOUR OF DEATH July 30, 1970 9:00 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 94 Villa Saint Michael			A. STATE Maryland B. COUNTY 2841		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4000 Forest Hill Road 21207		
5. SEX F.	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18, 1882	9. AGE (In years last birthday) 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse - retired		10B. KIND OF BUSINESS OR INDUSTRY Sister of Charity		11. BIRTHPLACE (State or foreign country) Northumberland, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Michael Tierney			
14. MOTHER'S MAIDEN NAME Ann Carroll		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 219-54-0770-J1		17. INFORMANT ADDRESS Sister Andrea - same address			
18. 440.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardio-vascular collapse			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: General Arteriosclerosis		
			(B) DUE TO, OR AS A CONSEQUENCE OF: 14 years		
			(C) _____		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) None	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) None		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January, 1956 19 to July, 1970 19, that (I) (we) last saw the deceased alive on July 28, 1970 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. No					
23A. SIGNATURE Damian P. Alagia, M.D.			23B. DATE SIGNED July 30, 1970		
23C. PHYSICIAN'S NAME (Type) Damian P. Alagia			23D. ADDRESS 3376 Indershan Blvd 29 Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/1/70		24C. NAME OF CEMETERY or CREMATORY Villa St. Michael on grounds Seton Institute	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS STEWART & MOWEN CO. 108 W. NORTH AVE (1)			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. C-640 70 7625				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7625		
1. NAME OF DECEASED (WALLACE C. CARROLL) (Type or Print) WALLACE CARROLL				2. DATE AND HOUR OF DEATH 7/29/70 3.45 P. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2605				
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore city hospitals 4940 Eastern Ave. Baltimore, Md. 21224		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN Baltimore 21224		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 703 Tolna St. 21224						007		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7-11-26	9. AGE (In years last birthday) 44	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper, Brewery Truck. Nat. Beer, Brewery		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles W. Carroll				14. MOTHER'S MAIDEN NAME Anna Hess				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 21M-20-7689		17. INFORMANT BCH Records: 4940 Eastern Ave. Baltimore, Md. 21224		ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) E881X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE RESPIRATORY INSUFF. DUE TO, OR AS A CONSEQUENCE OF: (B) BRAIN DAMAGE - @ EPI DU (C) 2AL HEMATOMA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 37/23/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED EPI DU 2AL HEMATOMA		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 703 Tolna St.		21D. TIME OF INJURY (APPROX.) 7-27-70 6-7p		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FELL DOWN FROM LADDER		22. I certify that (I) (this hospital) attended the deceased from 7/27/70 19 to 7/29/70 19 that (I) (we) last saw the deceased alive on 7/29/70 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE [Signature] DEGREE		
23B. DATE SIGNED 7/29/70		23C. PHYSICIAN'S NAME (Type) JUAN de Dios LOPEZ DEGREE		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		24A. BURIAL CREMATION, REMOVAL (Specify) Cremation Aug. 3. 1970		
24B. DATE Aug. 3. 1970		24C. NAME of CEMETERY or CREMATORY Greenmount Crematorium		24D. LOCATION (City, town, or county) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		
25B. NAME OF REGISTRAR Robert E. Jaber, M.D.		25C. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. Baltimore Md.		25D. ADDRESS		25E. DATE		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	70 7626
BIRTH NO. 0-241		70 7626		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) LILY LILLY A. OGILVIE			2. DATE AND HOUR OF DEATH July 30, 1970 8.00 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2714		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CERTIFICATE AMENDED - 11/10 421 Wingate Rd. Baltimore Md. 21210			C. CITY OR TOWN Baltimore 21210 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 421 Wingate Rd.					
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1891 79		9. AGE (In years last birthday)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? England
13. FATHER'S NAME Not Known Leopold Sheppard Ogilvie			14. MOTHER'S MAIDEN NAME Not Known Matilda Hills		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS S. Vannort Chapman. Atty. 21202 813 Mercantile Bldg. Baltimore Md
18. 440.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) INTERSELEOSIS			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 March 1968 to 30 July 1970 , that (I) (we) last saw the deceased alive on 29 July 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. G. Helfrich MD			23B. DATE SIGNED July 30, 1970		
23C. PHYSICIAN'S NAME (Type) WILLIAM G. HELFRICH M. D.			23D. ADDRESS 5006 Roland Ave. Baltimore Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE July 31, 1970		24C. NAME OF CEMETERY or CREMATORY Greenmount Crematorium	
24D. LOCATION (City, town, or county) Baltimore Md.		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC. Baltimore Md	

11/4/70 - Letter from S. Vannort Chapman, Atty. at Law, Personal Representative of
the Estate of Lily A. Ogilvie.

LFC

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Arthur Davis		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 30 70 12:00 p.m.	
6. SEX male		7. RACE colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 42		E. STREET AND NUMBER 1317 Stockton St.	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME Harry Davis		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Lula		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) ?	
17. SOCIAL SECURITY NO. 250-38-7202		18. INFORMANT Mrs Griffin, 1318 Stockton St	
19. CAUSE OF DEATH E-965X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		22C. WHERE DID INJURY OCCUR? 1317 Stockton St. 1501	
22D. TIME OF INJURY (Approx.) Month (Day) (Year) (Hour) 7 30 70 ? p.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? shot during altercation		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		DATE SIGNED 7/31/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/6/70	
24C. NAME OF CEMETERY OR CREMATORY Pamplico		24D. LOCATION (City, town, or county) (State) South Carolina	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North A e	

County of _____

State of Texas

1901

1901

Know all men by these presents

that _____ of the County of _____ State of Texas

do hereby certify that

_____ is the true and correct

copy of the

_____ of the

_____ of the

_____ of the

_____ of the

ACADEMY

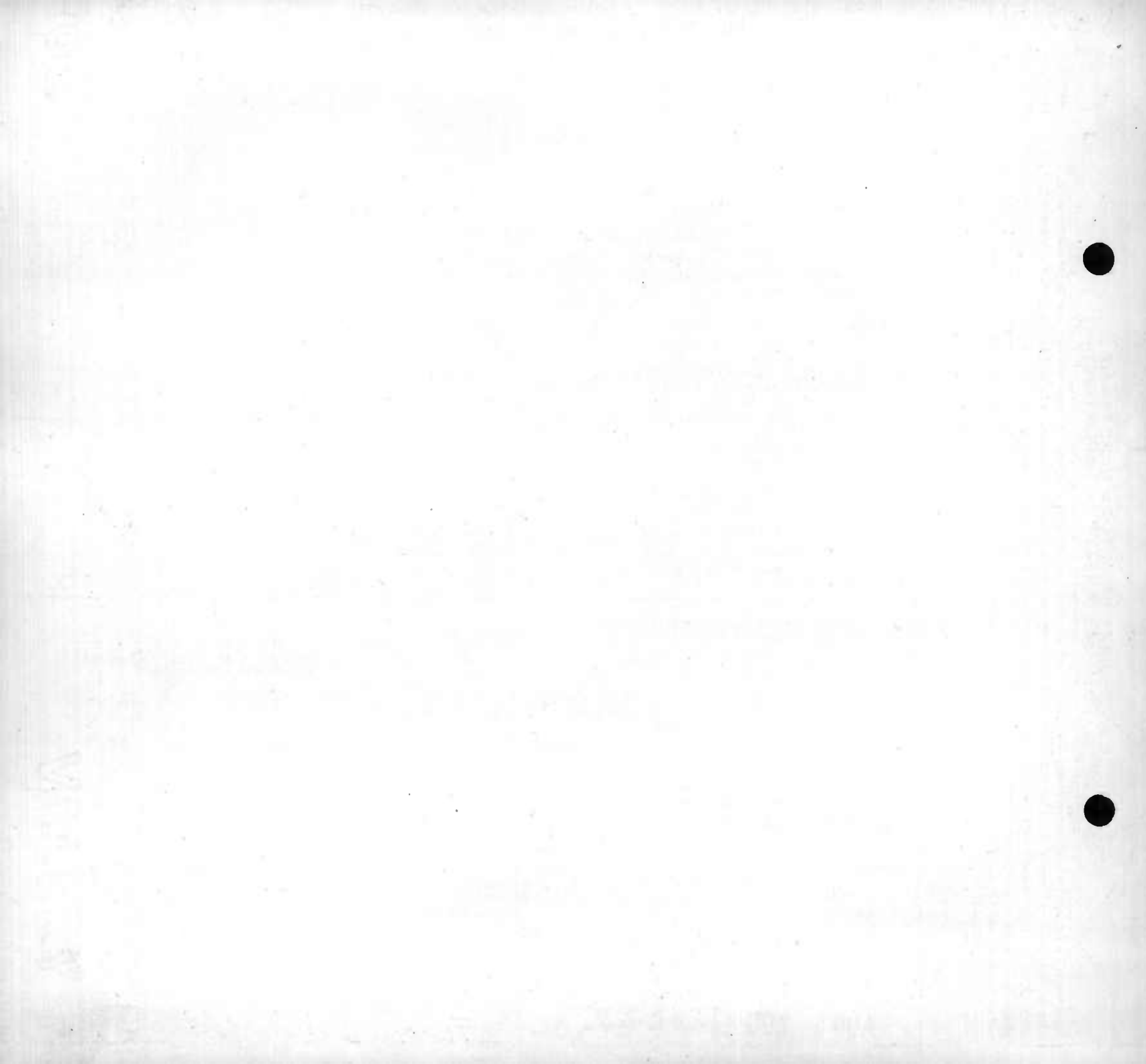
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7628	
BIRTH NO. 70 7628		1. NAME OF DECEASED (Type or Print) <u>Mary Ellen Nash</u>		2. DATE AND HOUR OF DEATH <u>July 30, 1970</u> <u>6:15 A.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>302</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>312 South High Street 21202</u>					
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-7-55</u>	9. AGE (in years last birthday) <u>15</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>STUDENT</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13. FATHER'S NAME <u>Larry</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Yost</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>BCH: Records Baltimore, Maryland 21224</u>	
18. <u>200.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u>		(A) IMMEDIATE CAUSE <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48L</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Skin ulcer</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>2d.</u>	
(C) <u>Lymphosarcoma</u>				<u>1 1/2 yr</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7-29</u> 19 <u>70</u> to <u>7-30</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>7-30</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John Brechtel M.D.</u>		23B. DATE SIGNED <u>7-30-70</u>			
23C. PHYSICIAN'S NAME (Type) <u>John Brechtel M.D.</u>		23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/370</u>		24C. NAME of CEMETERY or CREMATORY <u>BALTO. NEW NAT. CEM.</u>	
24D. LOCATION (City, town, or county) <u>BALTO. Md.</u>		24E. LOCATION (State) <u>BALTO. Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 3 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Frank D. [Signature]</u>	
25D. ADDRESS <u>322 S HIGH ST.</u>					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7629	
BIRTH NO. 70 7629		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Willie Jones			2. DATE AND HOUR OF DEATH April 22, 1970 10 15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Belt		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1625 Gough Street		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8/18/13	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 264-62-1319		17. INFORMANT ADDRESS	
18. 303.91 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Renal Failure (B) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF: Alcoholism (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 17 days 40 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/15 19 70 to 4/22 19 70 , that (I) we last saw the deceased alive on 4/22 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.					
23A. SIGNATURE James E. Muller MD			23B. DATE SIGNED 4/22/70		23C. PHYSICIAN'S NAME (Type) JAMES E. MULLER MD
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION 4/24/70 Greenmount			24B. DATE 4/24/70		24C. NAME OF CEMETERY OR CREMATORY BALTO. MD.
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970			25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Frank Della Noce 322 S HIGLEY



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7630	
BIRTH NO. 70 7630		1. NAME OF DECEASED (Type or Print) FRANCES BURKE FRANCES M. BURKE	
2. DATE AND HOUR OF DEATH AUGUST 31, 1970 12:05 A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CHURCH HOME + HOSPITAL Baltimore, Md. 21231	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 21206		5. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. STREET AND NUMBER 5937 Radocke Ave.		7. DATE OF BIRTH 5/8/1911 9. AGE (in years last birthday) 59	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WILLIAM WEAVER	
14. MOTHER'S MAIDEN NAME ANNIE WILD		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 220-05-2584		17. INFORMANT C.M. DE CASTRO, MD. ADDRESS CHURCH HOME + HOSPITAL	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Breast Cancer and Rectal Cancer with metastasis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. metastasis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 1964		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca breast	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/24 19 70 to 7/31 19 70 that (I) (we) last saw the deceased alive on July 31 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE unde castro		23B. DATE SIGNED AUGUST 31 1970	
23C. PHYSICIAN'S NAME (Type) CONCHITA DE CASTRO		23D. ADDRESS 100 N Broadway Baltimore MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-4-1970	
24C. NAME of CEMETERY or CREMATORY Mount Rose		24D. LOCATION (City, town, or county) (State) York, Pennsylvania	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Fisher, Md.	
25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.		ADDRESS 1901-07 Eastern Ave.	

Letter from Church Home and Hospital

8-5-70 M.H.

B-630

70 7631

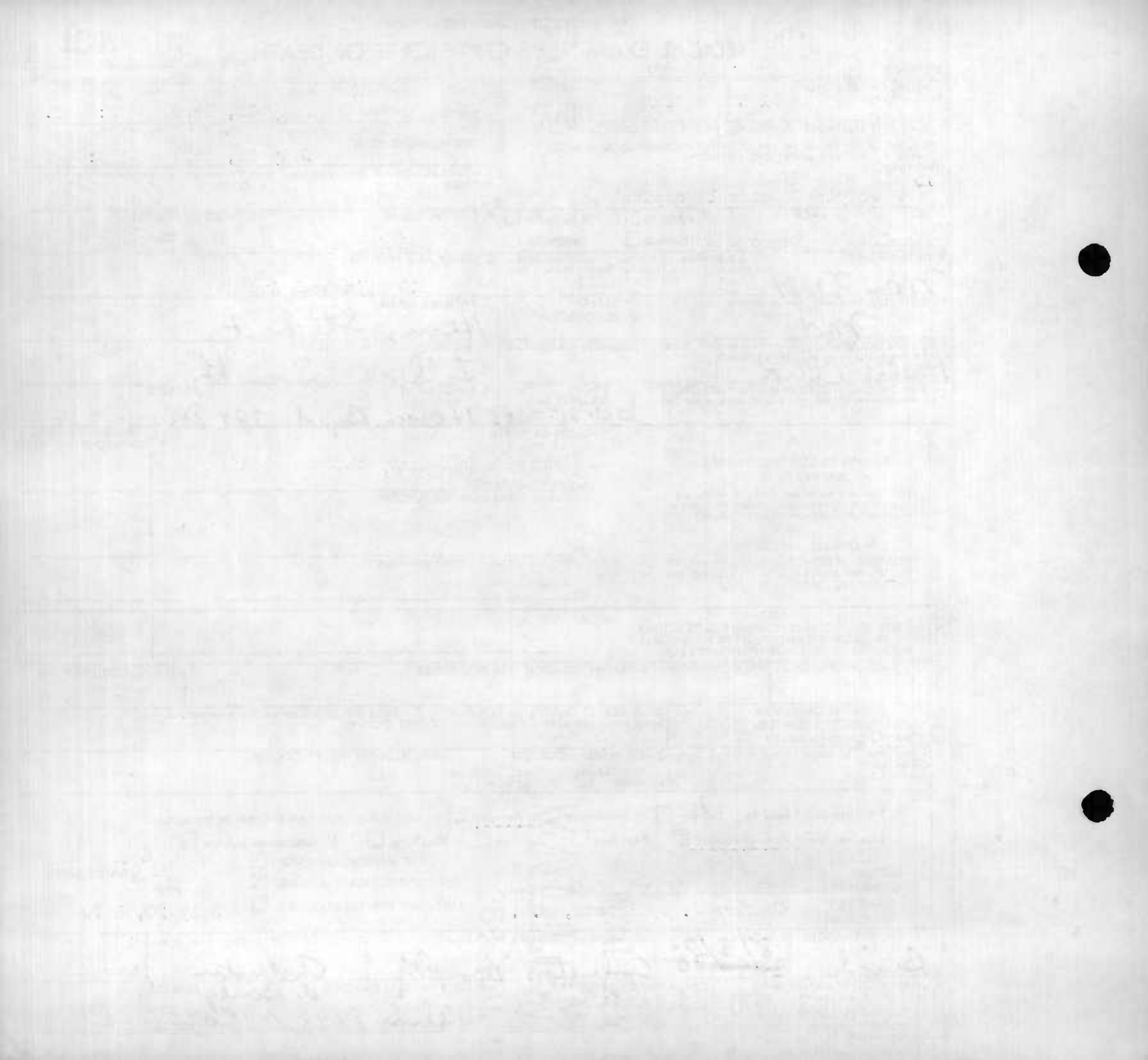
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 7631
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) VIOLET BYRD		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 29, 1970 Hour 8:00 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital		3. DATE PRONOUNCED DEAD Month Day Year July 29, 1970 Hour 8:00 P. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Mar 2, 1939		10. AGE (in years last birthday) 36	
11. BIRTHPLACE (State or foreign country) Ind		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Stewart		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk	
15. MOTHER'S MAIDEN NAME Lillian Smith		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 212-28-7586		18. INFORMANT Horace Byrd	
19. CAUSE OF DEATH 450X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Massive pulmonary thromboembolism (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21. AUTOPSY? (Yes or No) Yes	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 30, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/3/70	
24C. NAME OF CEMETERY or CREMATORY Arbutus mem pk		24D. LOCATION (City, town, or county) (State) Arbutus md	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR V. Bouley		ADDRESS 14345 N. Calhoun Ct	



Z-246

70 7632

BALTIMORE CITY HEALTH DEPARTMENT

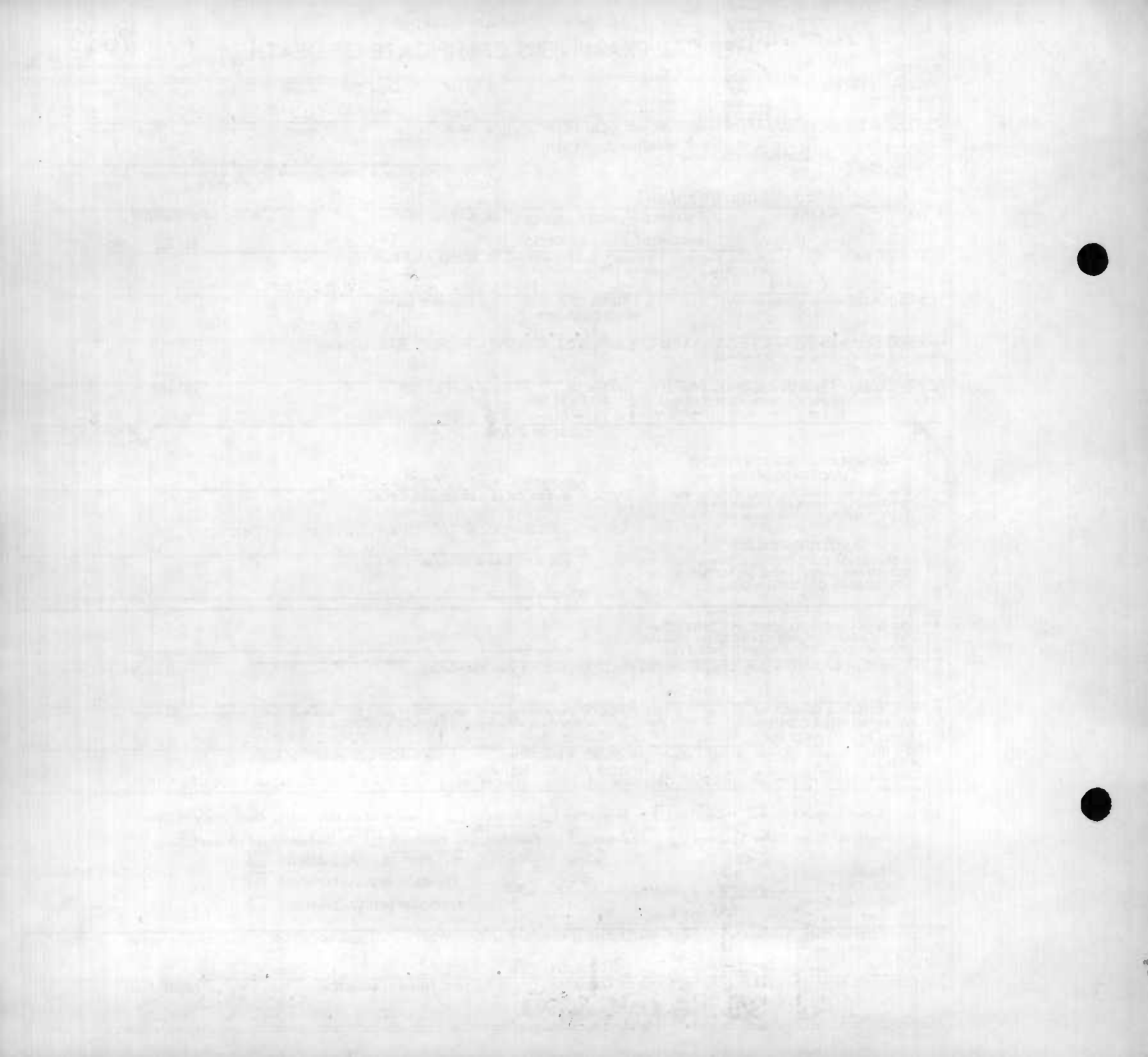
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 7632

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) SAMUEL ZEIGLER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year July 28, 1970 Hour 9:35 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year July 28, 1970 Hour 9:35 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3-16-16		10. AGE (In years lost birthday) 54	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes 11-29-40-12-27-41		17. SOCIAL SECURITY NO. 218-10-2415	
18. INFORMANT M. Thomas		ADDRESS 519 Robert Street	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E9261X PERITONITIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Peritonitis Stabwound of the flank with perforation of colon	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 7-25-70 11:20 P.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1503 Brunt Street		22F. HOW DID INJURY OCCUR? Stabbed during altercation	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mahalikis, M.D.		DATE SIGNED July 28, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-3-70	
24C. NAME of CEMETERY or CREMATORY Loudon Pk. Nat'l.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Faber, M.D.	
25C. FUNERAL DIRECTOR V. Bailey		ADDRESS Kelson FH. 1348 Calhoun Street	



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M. 200

70 7633

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 7633

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <u>James Albert MUSE</u>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <u>7</u> <u>25</u> <u>70</u> <u>1105</u> A M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>46 Lutheran Hospital</u>		3. DATE PRONOUNCED DEAD Month Day Year Hour <u>7</u> <u>25</u> <u>70</u> <u>1105</u> A M.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>604</u>			
6. SEX <u>M</u>	7. RACE <u>Negro</u>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	C. CITY OR TOWN <u>Baltimore</u>
9. DATE OF BIRTH <u>8/8/27</u>		10. AGE (In years last birthday) <u>42</u>	E. STREET AND NUMBER <u>1817 Fairmount Ave</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>James Muse Sr.</u>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME <u>Hazel Holmes</u>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>2/8/46</u>		17. SOCIAL SECURITY NO.	18. INFORMANT ADDRESS <u>Hilda Tucker 530 N. Mount. St.</u>
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (A) IMMEDIATE CAUSE <u>Narcotic addiction</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) m. _____		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <u>yes</u>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>[Signature]</u> M.D. EXAMINER'S NAME (Type) <u>Robert E. Spitz, M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Deputy Chief Medical Examiner</u> DATE SIGNED <u>7, 26, 70</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/4/70</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park (Nat.)</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 3 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Spitz, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Kelson F.H.</u>		25D. ADDRESS <u>1348 N. Calhoun St.</u>	

ACADEMY BOND

WARRANT

VALLEY BOND CO

U.S.A.

R-560

70 7634

BALTIMORE CITY HEALTH DEPARTMENT

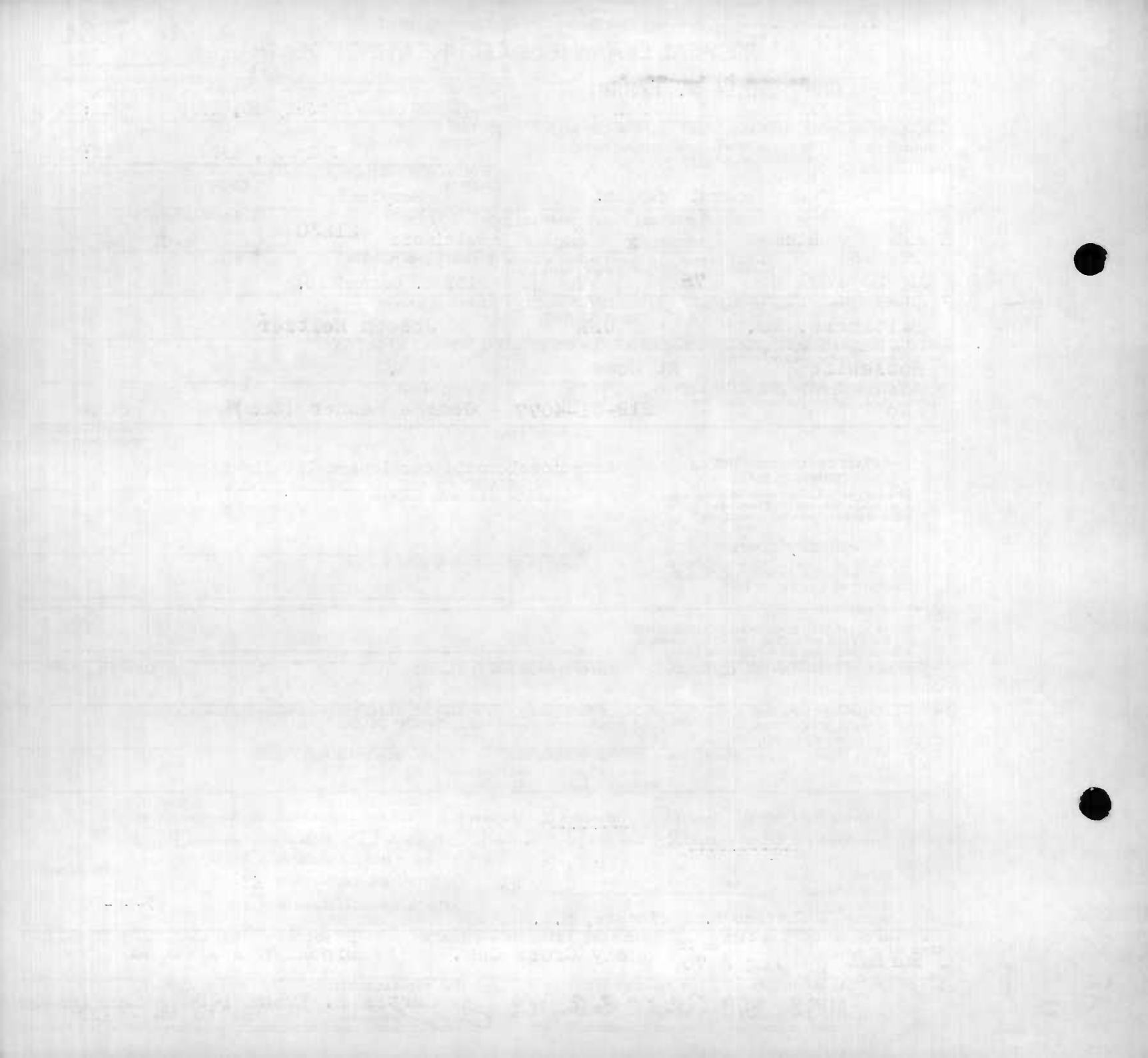
70 7634

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

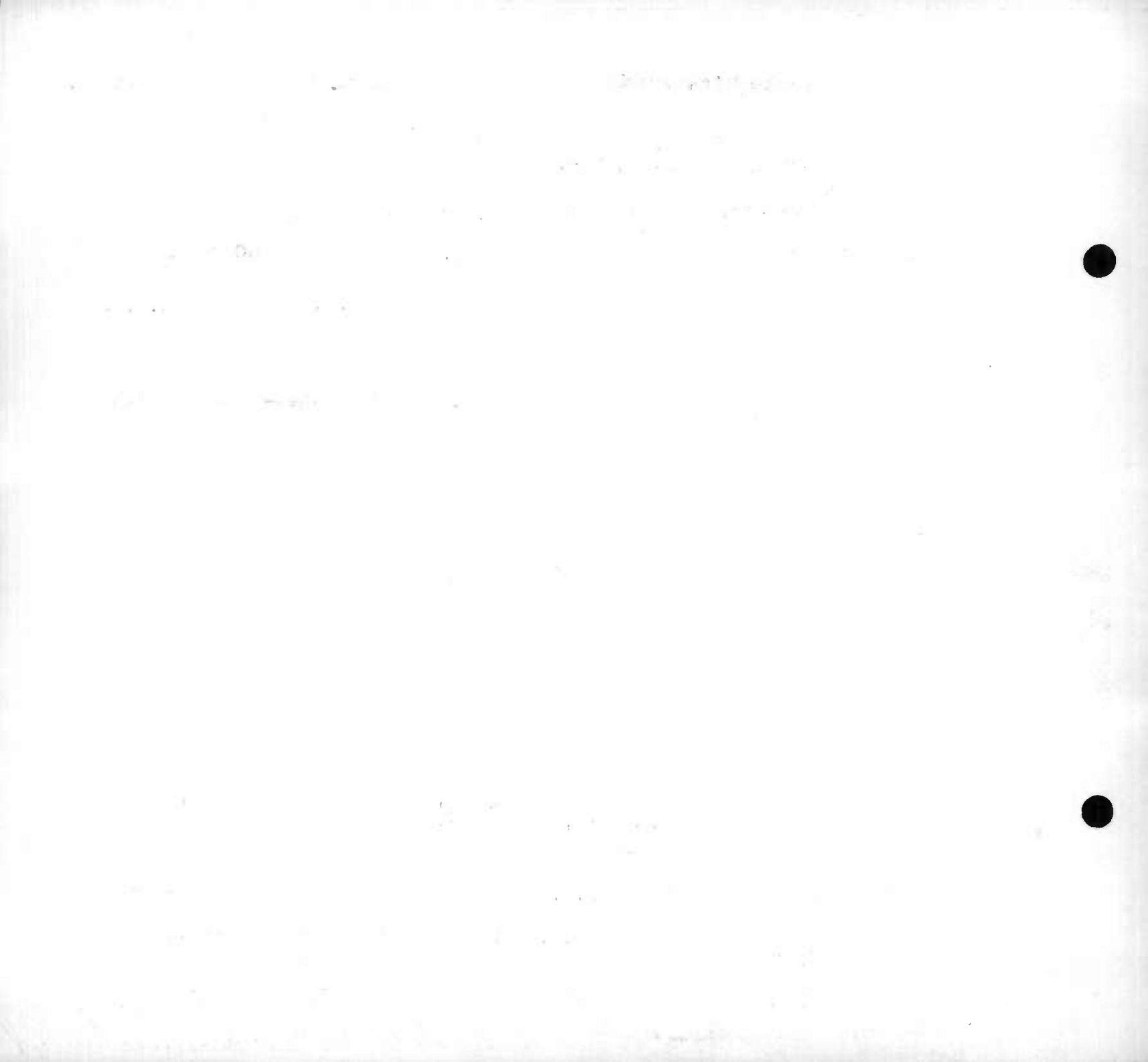
1. NAME OF DECEASED (Type or Print) ANNA RENNER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year July 30, 1970 Estimated <input type="checkbox"/> 11:22 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month Day Year July 30, 1970 11:22 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore 21230	
9. DATE OF BIRTH Aug 23 1891		10. AGE (in years last birthday) 78	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY At Home	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 219-01-4077	
18. INFORMANT George Renner (Son)		ADDRESS Same	
19. 412.4 CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Arteriosclerotic cardiovascular disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Mon Aug 3 70	
24C. NAME OF CEMETERY or CREMATORY Holy Cross Cem.		24D. LOCATION (City, town, or county) (State) Brooklyn A A Co Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Curtis E. Evans		ADDRESS 1400 S Charles St Balto Md 21230	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

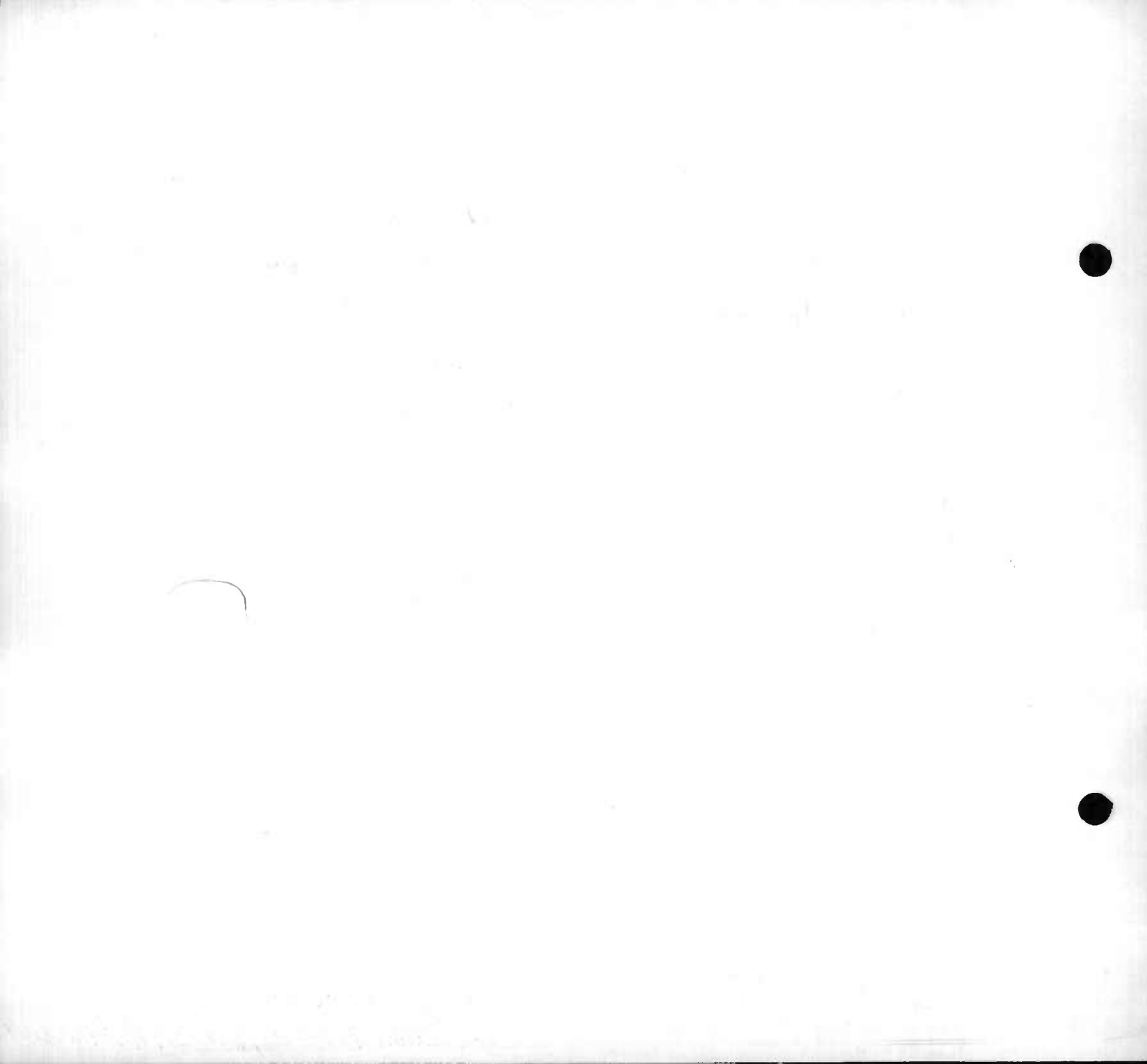
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7635</u>	
R-263 70 7635		BIRTH NO. <u>70 7635</u> CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Gable Richardson			2. DATE AND HOUR OF DEATH 7-30-70 6:45 p.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1601		
5. SEX Male 6. RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Sept. 6, 1909 9. AGE (in years last birthday) 60 If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			11. BIRTHPLACE (State or foreign country) Winnsboro S.C.		
13. FATHER'S NAME James Richardson			14. MOTHER'S MAIDEN NAME Resie ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 705-12-2014		
17. INFORMANT Mrs. Estelle Richardson			ADDRESS SAME		
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial Infarction Cerebrovascular accident			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 7/30/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 29, 1970 to July 30, 1970 that (I) (we) last saw the deceased alive on July 30, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE William G. Foot M.D. DEGREE				23B. DATE SIGNED 7-31-70	
23C. PHYSICIAN'S NAME (Type) William G. Foot				23D. ADDRESS 1514 Division Street Balto., Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/4/70		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
24D. LOCATION Balto. Md.		24E. NAME OF REGISTRAR Robert E. Fabela, M.D.		24F. FUNERAL DIRECTOR Williams Funeral Home 3198 So. Howard St.	
25A. DATE RECD BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Fabela, M.D.		25C. FUNERAL DIRECTOR Williams Funeral Home 3198 So. Howard St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

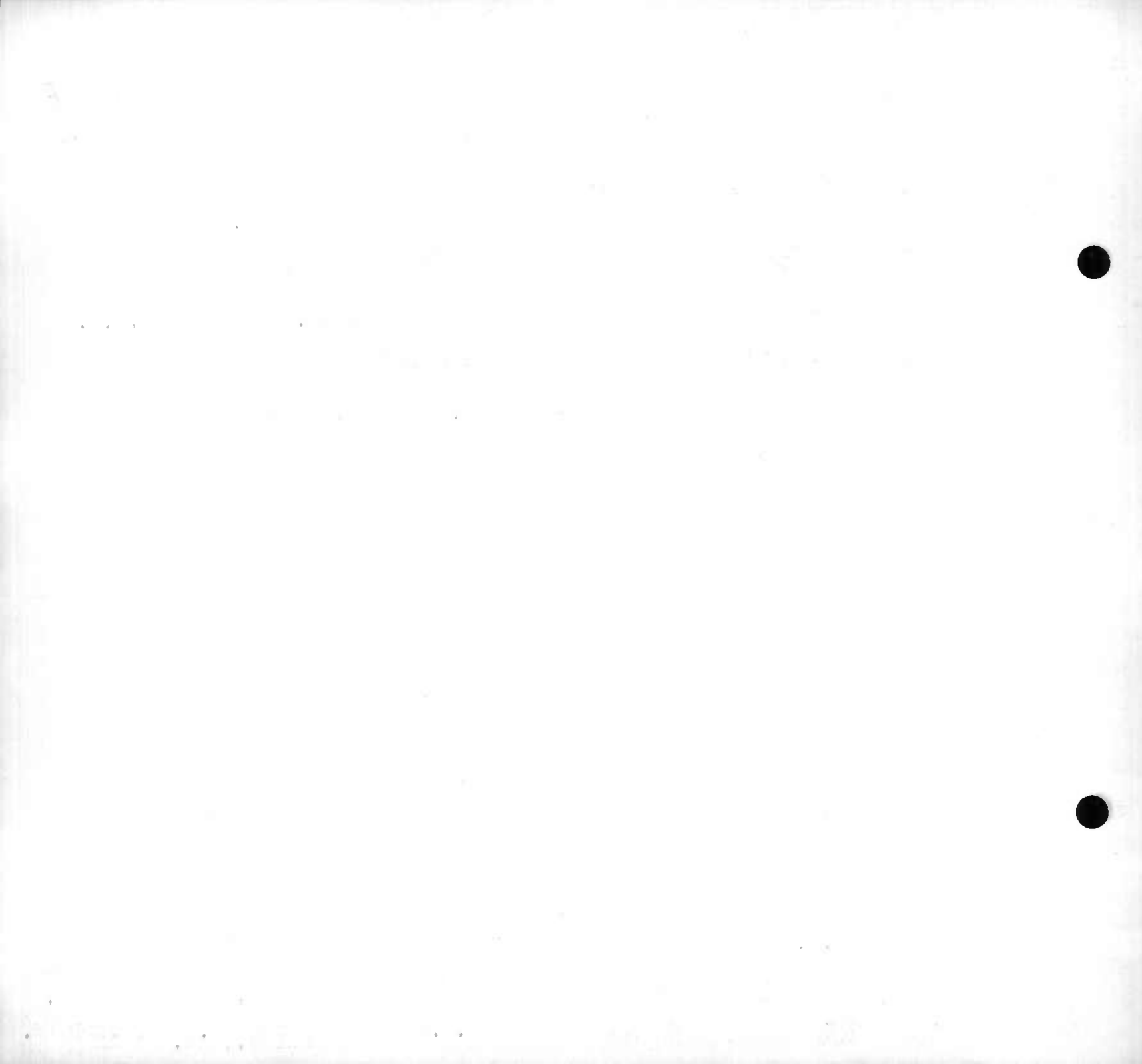
W-614 70 7636				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7636	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) MARGARET WARFIELD		2. DATE AND HOUR OF DEATH 7-30-70 12:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1802			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS Hospital 34				C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 119 N. CARROLLTON AVE.			
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-8-1901 69		9. AGE (in years last birthday) 69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD, BALTO.	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Daniel Hunt		14. MOTHER'S MAIDEN NAME Ellen Lewis	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 213-12-2550		17. INFORMANT Admission Sheet	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. C.V.A.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) Hypertension			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) -		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -			
22. I certify that (I) (this hospital) attended the deceased from 7/29 19 70 to 7/30 19 70 that (I) (we) last saw the deceased alive on 7/30 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Kusuma K. Pruksapong				23B. DATE SIGNED 7/30/70			
23C. PHYSICIAN'S NAME (Type) DR. KUSUMA K. PRUKSAPONG MD				23D. ADDRESS Bon Secours Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/3/70		24C. NAME OF CEMETERY OR CREMATORY St. Lukes Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE RECEIVED BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR Williams Funeral Home		25D. ADDRESS 3199 N. Schroeder Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-152		70 7637		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7637	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Evans, Mildred Smith</u>				8/1/70 11 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Johns Hopkins Hospital</u>				A. STATE MARYLAND B. COUNTY BALTIMORE CITY			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 1101 N. CALVERT ST.							
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/14/1908	9. AGE (In years last birthday) 62	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ray Ramsay Smith				14. MOTHER'S MAIDEN NAME Susanna Twigg			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-24-0064			
17. INFORMANT Dr. Gerald A. Evans (Same)				ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>interlobar pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (A) (this hospital) attended the deceased from 8/1/70 19 70 to AUGUST 1 19 70 that (A) (we) last saw the deceased alive on AUGUST 1 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>J.M. Amatruda MD</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/1/70	
23C. PHYSICIAN'S NAME (Type) J.M. AMATRUDA				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/70		24C. NAME of CEMETERY or CREMATORY Hillcrest		24D. LOCATION (City, town, or county) (State) Cumberland, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto., Md. 21212	

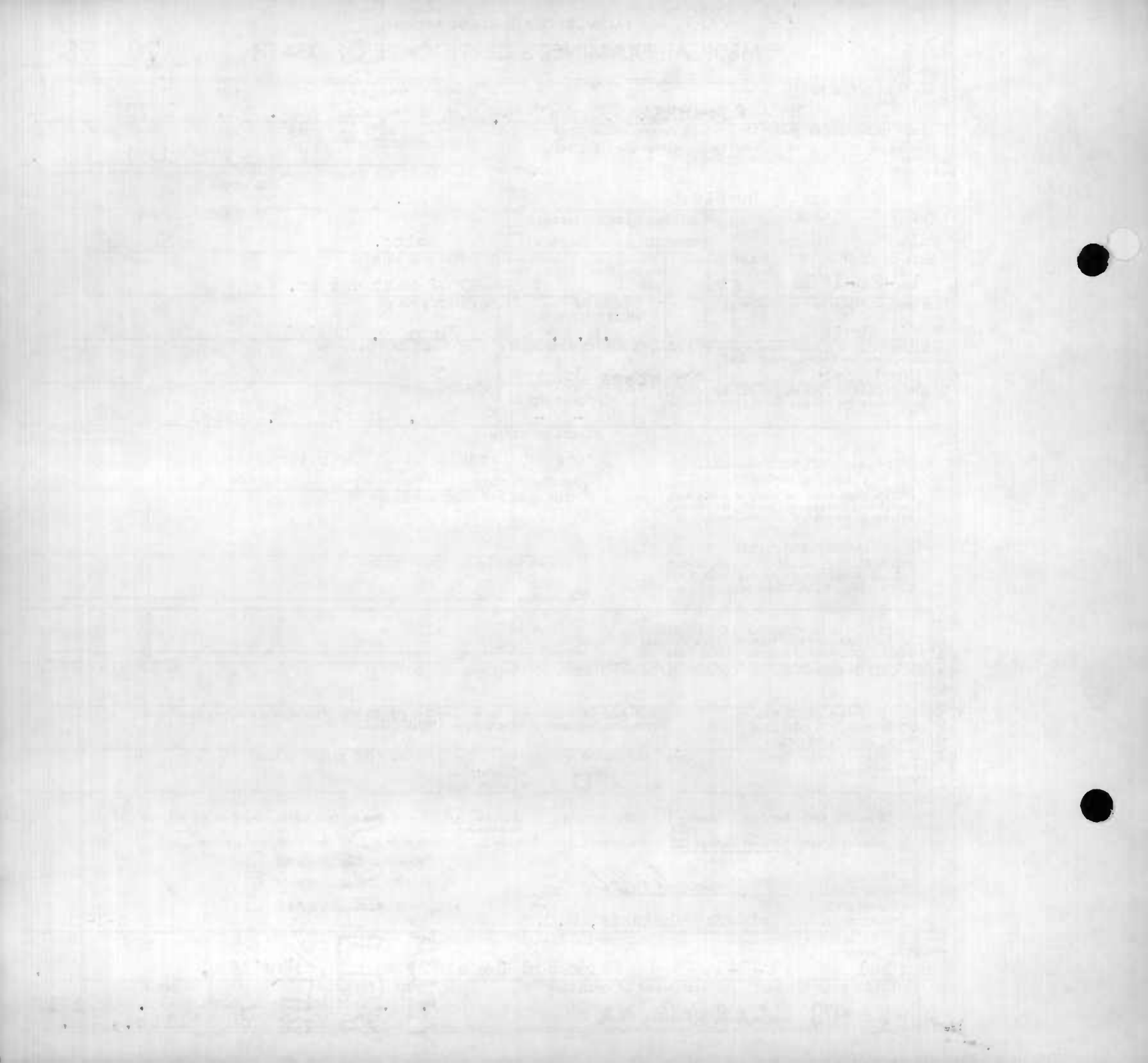


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7638

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES Franklin Daniel Sr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Aug. 1, 1970 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 1 1970 1:15 P.M.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Md. B. COUNTY 904	
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 11-26-1902	10. AGE (In years last birthday) 67	E. STREET AND NUMBER 3047 Matthews St.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		13. FATHER'S NAME John F. Daniel	
14B. KIND OF BUSINESS OR INDUSTRY Koesters Bakery		15. MOTHER'S MAIDEN NAME ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 800-00-9729	
18. INFORMANT Mrs. Charles F. Daniel		ADDRESS Same	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. DATE SIGNED 8-2-70 EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-5-1970	24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	24D. LOCATION (City, town, or county) (State) Parkville, Md.
25A. DATE REC'D BY HEALTH DEPT. AUG 3 1970	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 21212 4905 York Road Balto., Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 7639		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7639	
1. NAME OF DECEASED (Type or Print) ANNIE H. GORRELL			2. DATE AND HOUR OF DEATH AUGUST 1, 1970 4:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 LUTHERAN HOSP.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1607 C. CITY OR TOWN BALTIMORE MD. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1130 DODDAR GROVE ST.		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-89	9. AGE (in years last birthday) 80	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
13. FATHER'S NAME JAMES HARRIS			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME ELIZABETH	
17. INFORMANT Shirley Gorrell, Son - SAME			ADDRESS		
18. 436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cerebrovascular Accident ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from JULY 15, 1970 to AUGUST 1, 1970 that we (we) last saw the deceased alive on AUGUST 1, 1970 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) (did not) view the body after death.					
23A. SIGNATURE Christos Dibranos, M.D.				23B. DATE SIGNED AUG. 1, 1970	
23C. PHYSICIAN'S NAME (Type) CHRISTOS DIBRANOS, M.D.		23D. ADDRESS 730 ASHBURTON STR., BALTO., MD. 21216			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-7-70		24C. NAME OF CEMETERY OR CREMATORY NATIONAL CEM.	
24D. LOCATION (City, town, or county) DANVILLE, VIRGINIA		24E. STATE (State) BALTO., MD.			
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS CHARLES H. RICE 66 W. BARRE ST. BALTO., MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7640	
BIRTH NO. 70 7640		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) PEARL SMITH			2. DATE AND HOUR OF DEATH 8/2/70 10-00 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1537		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND 46			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2510 NORTH ELLAMONT ST.		
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH -03	9. AGE (In years last birthday) 67 yrs	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME SQUIRE SMITH		14. MOTHER'S MAIDEN NAME unk.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Andrew Brower 600 Roundview Rd.	
18. 70701 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) SEPTICAEMIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MULTIPLE DECUBITUS ULCERS WITH PNEUMONIA			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)..... APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) NO -	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 7/28/1970 to 8/2/1970 , that (I) (we) last saw the deceased alive on 8/2/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Basu DEGREE				23B. DATE SIGNED 8/2/70	
23C. PHYSICIAN'S NAME (Type) S. BASU		23D. ADDRESS Lutheran Hospital of Maryland DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-6-70		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary	
24D. LOCATION (City, town, or county) (State) Brooklyn, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970			
25B. NAME OF REGISTRAR Robert E. Jarboe, M.D.		25C. FUNERAL DIRECTOR CHARLES A. RICE 661 W. BARRE ST.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
J-260		70 7641		70 7641	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
John T. Jaeger		July 25 1970 8 ³⁰ P.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
90 Wesley Home		Maryland		131 st Md	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		2211 West Rogers Ave.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
M.	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	17 Apr 1880	90	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Clergyman		Methodist Church		Washington, D.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
William Jaeger		Rosima E. Bentz			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		213 36 3272A		Wesley Home same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) INTERMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 30 June 1970 to 25 July 1970, that (I) (we) last saw the deceased alive on 25 July 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
John W. Barnaby		28 July 70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
John W. Barnaby		1652 East Belvedere Ave			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		28 Apr 70		Parkwood Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 4 1970		Robert E. Jaeger, M.D.		Burgess Funeral Home, Balt. Md.	

called nursing home for prior address - Thinks he
lived with daughter at Box 28, Leonardtown, Md.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Hall, Edward

2. DATE AND HOUR OF DEATH

7/30/70

1 10 5 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Baltimore City Hospital
4940 Eastern Avenue
Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

335 S. Clinton St., Balto., Md. 21224

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

8-14-87

9. AGE (In years
last birthday)

82

If Under 1 Yr.
Months: Days:If Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

State

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Richard

14. MOTHER'S MAIDEN NAME

Annie

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

VAK

16. SOCIAL
SECURITY NO.

212-01-9237

17. INFORMANT

4940 Eastern Avenue
BCH Records: Balto., Md. 21224

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Sepsis

(B) ASVD (atherosclerotic)
DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

multiple CVD

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO -

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-14-70 19 to 7-30-70 19
that (I) (we) last saw the deceased alive on 7-30 19 70 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ronald Blum, M.D.

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7/30/70

23C. PHYSICIAN'S
NAME (Type)

Ronald Blum, M.D.

DEGREE

23D. ADDRESS

Baltimore City Hospital
4940 Eastern Ave., Balto., Md. 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

8/3/70

24C. NAME OF CEMETERY or CREMATORY

SACRED HEART

24D. LOCATION

BALTO. MD

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 4 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

J. H. Connolly 300 N. Calver St.

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-400		70 7643		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 7643	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) MRS. MARY HEIL				2. DATE AND HOUR OF DEATH 7/31/70 8:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore				5. CITY OR TOWN BALTIMORE	
6. FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL BALTIMORE, MARYLAND 21231				7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				8. STREET AND NUMBER 6116 BELAIR RD.	
9. SEX F		10. RACE W		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12. DATE OF BIRTH 11/28/95		13. AGE (in years last birthday) 74	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALAD GIRL		15. KIND OF BUSINESS OR INDUSTRY TELEPHONE		16. BIRTHPLACE (State or foreign country) PHILADELPHIA		17. CITIZEN OF WHAT COUNTRY? AMERICA		18. FATHER'S NAME JOSEPH KAUT	
19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		20. SOCIAL SECURITY NO.		21. MOTHER'S MAIDEN NAME JOSEPHINE SCHMID.		22. INFORMANT JOSEPH HEIL		23. ADDRESS 7218 GOUCHST.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 00391 CAUSE OF DEATH Cardiorespiratory arrest				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(B) DUE TO, OR AS A CONSEQUENCE OF: Septicemia & Shock					
(C) Salmonellosis									
24. DATE OF OPERATION O		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No)		27. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
28. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
31. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		32. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		33. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 7/30 1970 to 7/31 1970 that (I) (we) last saw the deceased alive on 7/31 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE A.C. Chauvalit, M.D.				23B. DATE SIGNED 7/31/70		23C. PHYSICIAN'S NAME (Typo) A.C. CHOUVALIT, M.D.		23D. ADDRESS CHURCH HOME & HOSPITAL BALTO, MD. 21231	
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 8/3/70		24C. NAME OF CEMETERY OR CREMATORY HOLY CROSS		24D. LOCATION (City, town, or county) (State) UPPER DARBY PA.			
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR J. H. Brimley		25D. ADDRESS 300 Race Ave			

Letter from Church Home and Hospital
8-27-70 M.H.

4E 7218 Gough St.

CERTIFICATE OF DEATH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

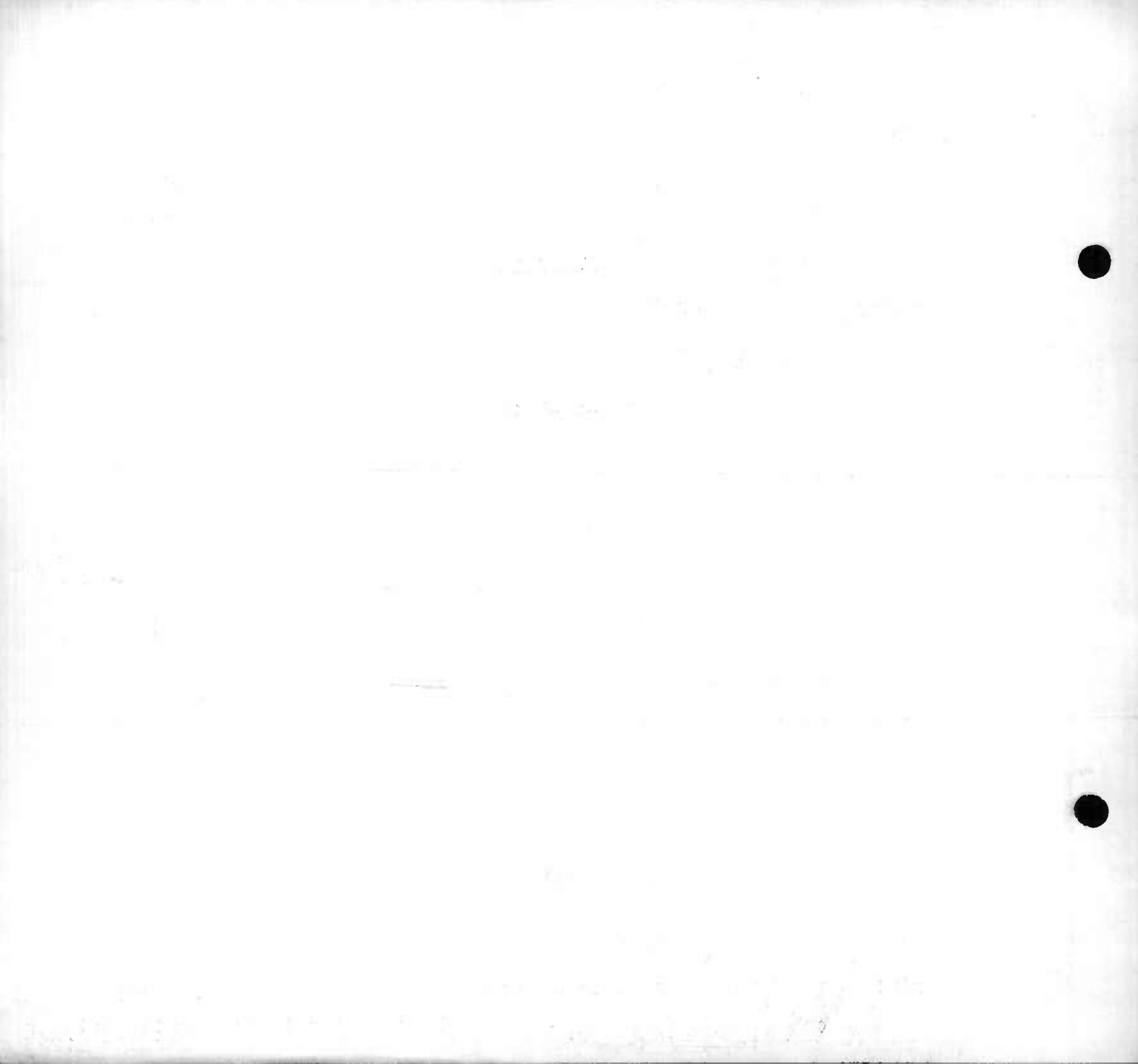
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Michael L. Scarantino</u>		2. DATE AND HOUR OF DEATH <u>7/31/70</u> <u>1945</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>ESSEX</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>48 B Fenway South 21222</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-13-04</u>	9. AGE (in years last birthday) <u>65</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DETECTIVE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Tom Scarantino</u>			
14. MOTHER'S MAIDEN NAME <u>Lena</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK</u>			
16. SOCIAL SECURITY NO. <u>213-18-7083</u>		17. INFORMANT <u>BCH Records - 4940 Eastern Ave. Balto. Md. 21224</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>transitional cell carcinoma of ureter</u> CAUSE OF DEATH II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>10/67 - nephrosarcoma</u> <u>2200 - transitional cell carcinoma of ureter</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>10/67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>carcinoma of ureter</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner) <u>no</u>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7/12/70</u> 19 <u>70</u> to <u>7/31</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>7/31</u> <u>945am</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harry Pond</u>				23B. DATE SIGNED <u>7/31/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Harry Pond M.D.</u>				23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/4/70</u>		24C. NAME of CEMETERY or CREMATORY <u>GARDENS OF FAITH</u>	
24D. LOCATION <u>BALTO. MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>		25C. FUNERAL DIRECTOR <u>J. J. Connelly, Jr. 300 N. ...</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

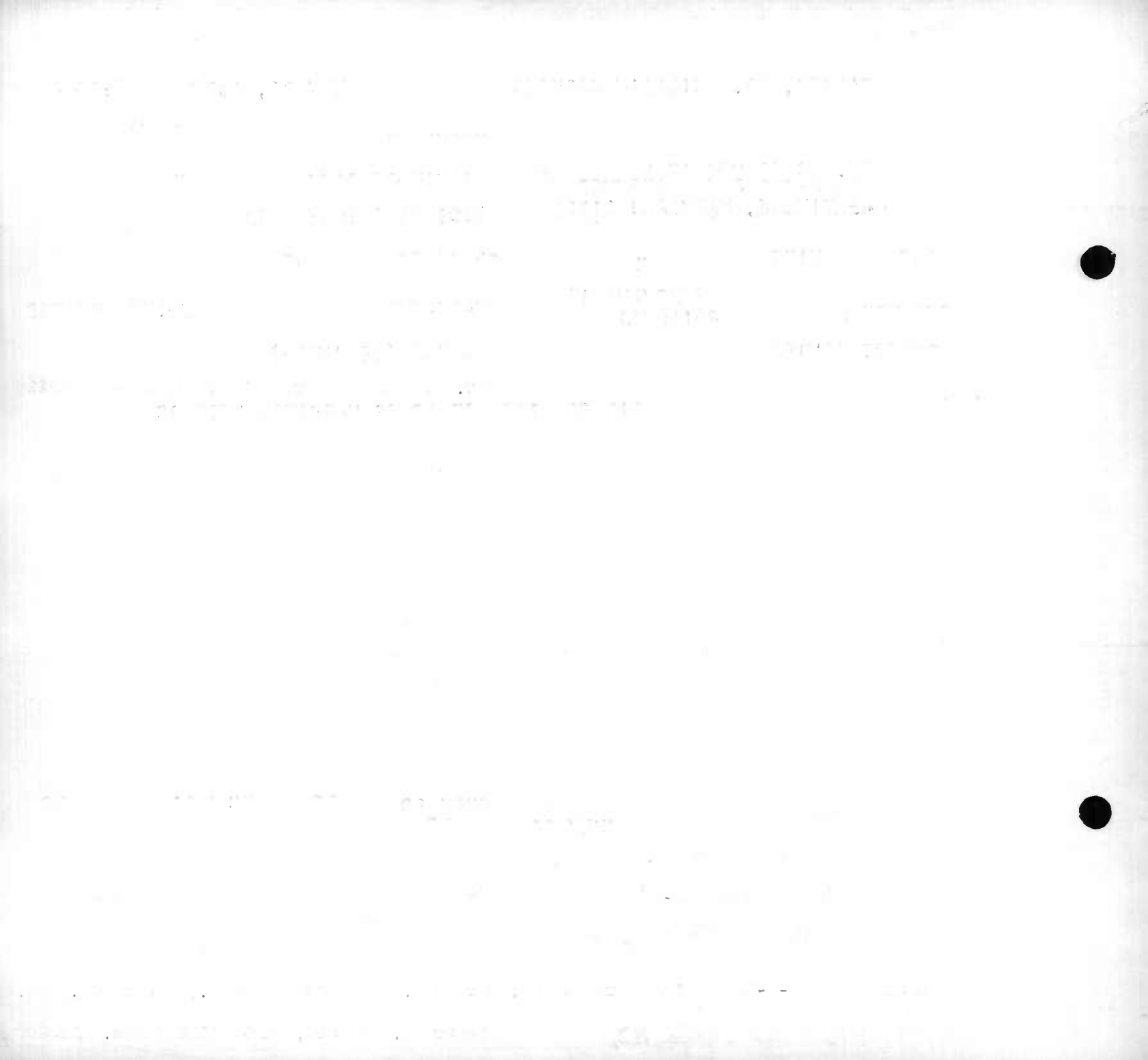
BIRTH NO. <u>B-260</u>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7645</u>			
1. NAME OF DECEASED (Type or Print) <u>DELLA M. BAKER</u>				2. DATE AND HOUR OF DEATH <u>JULY 31 70</u> <u>4:40 A.M.</u>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIV. OF MARYLAND HOSP.</u> <u>38</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1902</u>				C. CITY OR TOWN <u>BALTIMORE</u>			
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER <u>1509 W. PRATT Street</u>			
5. SEX <u>F</u>		6. RACE <u>CAUC.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-29-03</u>		9. AGE (In years last birthday) <u>66</u>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Packer</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Fruit</u>				11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Thomas WATERS</u>				14. MOTHER'S MAIDEN NAME <u>ANNA McFARLAND</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>235-18-7315</u>		17. INFORMANT <u>SELF + SISTER</u>				ADDRESS <u>SAME</u>	
18. <u>180X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY EMBOLUS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>WOUND DEPRESSION, INFECTION SEPSIS</u> <u>CARCINOMA OF CERVIX</u> <u>ACUTE RENAL FAILURE, ENTERIC FISTULA</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PULMONARY EMBOLUS</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>WOUND DEPRESSION, INFECTION SEPSIS</u> (C) DUE TO, OR AS A CONSEQUENCE OF: <u>CARCINOMA OF CERVIX</u> <u>ACUTE RENAL FAILURE, ENTERIC FISTULA</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 Wk</u> <u>5 Yr</u> <u>3 Wk</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>ACUTE RENAL FAILURE, pneumonia, Enteric FISTULA</u>											
19A. DATE OF OPERATION <u>6/25/70</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>RECURRENT CA OF CERVIX</u>				20A. AUTOPSY? (Yes or No) <u>NO</u>			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>N/D</u>				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>UNIV. HOSP.</u>			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>7/31</u>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				22. I certify that (I) (this hospital) attended the deceased from <u>6/24/70</u> 19 <u>70</u> to <u>7/31</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>7/31</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Sharon B. Satterfield MD</u>				23B. DATE SIGNED <u>7/31/70</u>				23C. PHYSICIAN'S NAME (Type) <u>SHARON B. SATTERFIELD M.D.</u>			
23D. ADDRESS <u>UNIV. HOSP.</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>08/03/70</u>			
24C. NAME OF CEMETERY OR CREMATORY <u>Crest Lawn Gardens</u>				24D. LOCATION (City, town, or county) (State) <u>Howard County, Maryland</u>				25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>				25C. FUNERAL DIRECTOR <u>Walters Funeral Home</u>				25D. ADDRESS <u>Pratt & Stricker Streets 21223</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 70 7646	
C-436 70 7646		BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CALDER, SR. WILLIAM JACKSON			2. DATE AND HOUR OF DEATH JULY 31, 1970 8:00 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE CITY D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4603 MANORDENE ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04 06 80	9. AGE (In years last birthday) 90	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONDUCTOR		10B. KIND OF BUSINESS OR INDUSTRY PENNSYLVANIA RAILROAD		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ROBERT CALDER			14. MOTHER'S MAIDEN NAME LAURA (BENJAMIN)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 717 07 8170		17. INFORMANT Mr. Kenneth Calder, 636 Braeside Road 21229 ST AGNES HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4-12-41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A.S.C.V.D. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from JULY 30 1970 to JULY 31 1970 that (I) (we) last saw the deceased alive on JULY 31 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. C. Pound			23B. DATE SIGNED 8/1/70		
23C. PHYSICIAN'S NAME (Type) J. C. Pound			23D. ADDRESS 3325 Frederick Ave		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-3-1970	24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem. Park Cem.		24D. LOCATION (City, town, or county) (State) Washington Blvd., Howard Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7647

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARGARET ANN CURRY MOSELEY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour July 30, 1970 2:10 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 6-26-1949		10. AGE (In years lost birthday) 21	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Mr. Marshall J. Moseley, 2119 Callow Ave.		ADDRESS 21217	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Intravenous narcotism (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. DATE SIGNED 7-30-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-3-1970	
24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

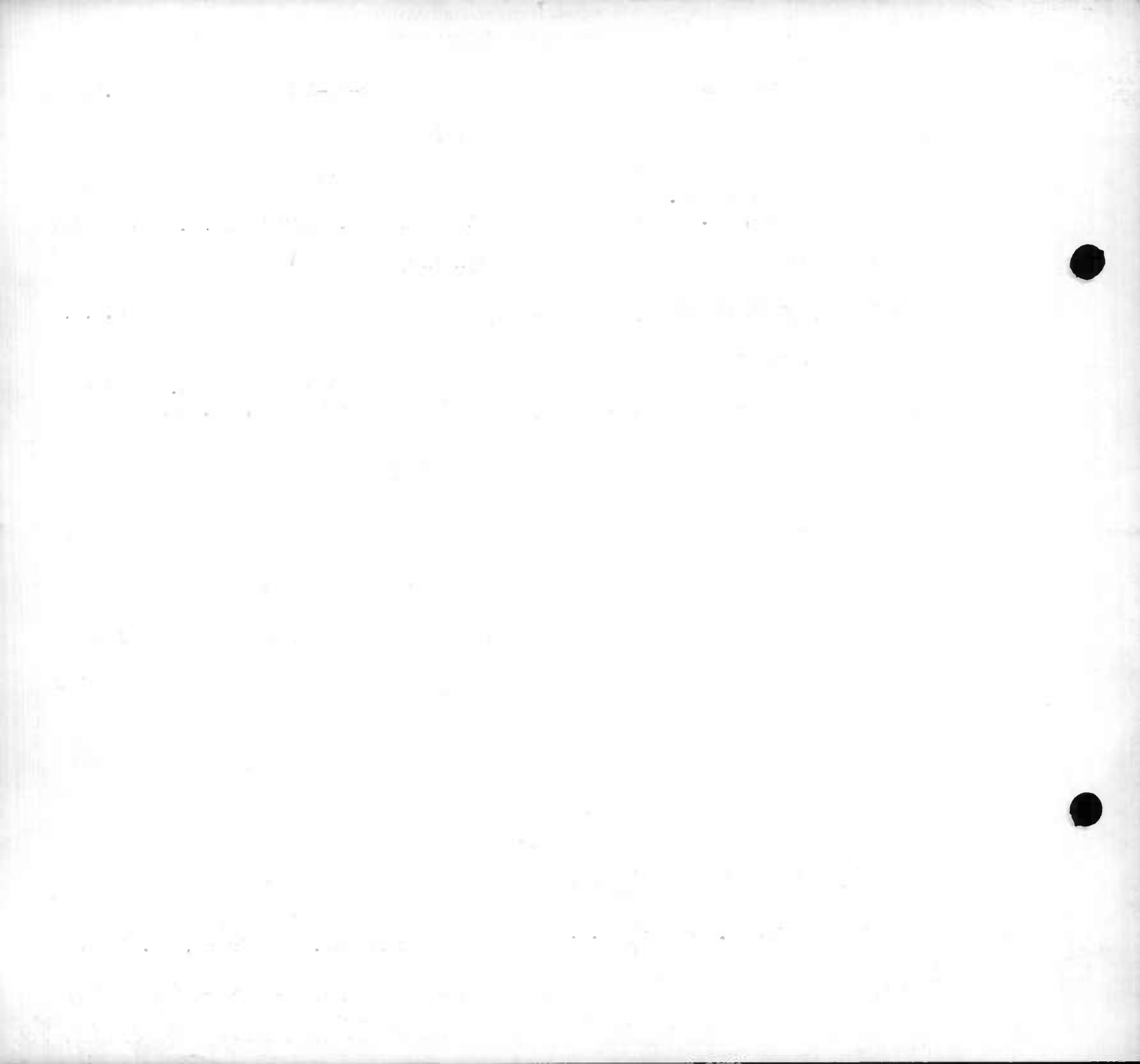
B-430 70 7648 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 7648	
1. NAME OF DECEASED (Type or Print) PAULINE R. BELT			2. DATE AND HOUR OF DEATH 31 July 1970 8-45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Reisterstown 5300		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Union Memorial Hospital Baltimore - Maryland 21218			C. CITY OR TOWN Reisterstown		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 11-19-1925 9. AGE (In years last birthday) 44 years		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? AMERICA		
13. FATHER'S NAME George Royston			14. MOTHER'S MAIDEN NAME Hilda Chilcoat		
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown			16. SOCIAL SECURITY NO. 219-10-1934		17. INFORMANT Mr. Samuel W. Belt ADDRESS Reisterstown, Md.
18. 195-01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinomatous abdomen			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Renal failure			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinomatous abdomen		
(B) DUE TO, OR AS A CONSEQUENCE OF:			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Renal failure					
19A. DATE OF OPERATION 3/21/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Salvage of central obstruction		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 1970		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/20/1970 19 to 7/31/1970 19 that (I) (we) last saw the deceased alive on 7/30/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. F. Eline			23B. DATE SIGNED 7/31/1970		23C. PHYSICIAN'S NAME (Type) J. F. Eline
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE Aug. 6, 70		24C. NAME OF CEMETERY OR CREMATORY Dover Cemetery
24D. LOCATION (City, town, or county) Glyndon, Md.			25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		
25B. NAME OF REGISTRAR Robert E. J. F. Eline			25C. FUNERAL DIRECTOR J. F. Eline & Sons ADDRESS Reisterstown, Md.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-220 70 7649		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 7649	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Norma Lucas		7-28-1970 3.30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		Maryland Anne Arundel		5200	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Assistant Publicity Director U.S. Naval Academy		Maryland		11-22-31	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (in years last birthday)	
Marcellas Windsor		Lena		38	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		215-38-0508		4940 Eastern Ave. ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF		5 min	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF		8 hrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF		2 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Concussion of Liver		2 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7-28-70 to 7-28-70 that (I) (we) last saw the deceased alive on 7-28-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John R. Brechtel M.D.				7-28-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
John R. Brechtel M.D.				Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/1/70		Sherbert Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 4 1970		Robert E. Taylor, M.D.		John M. Taylor & Sons Annapolis, Md.	

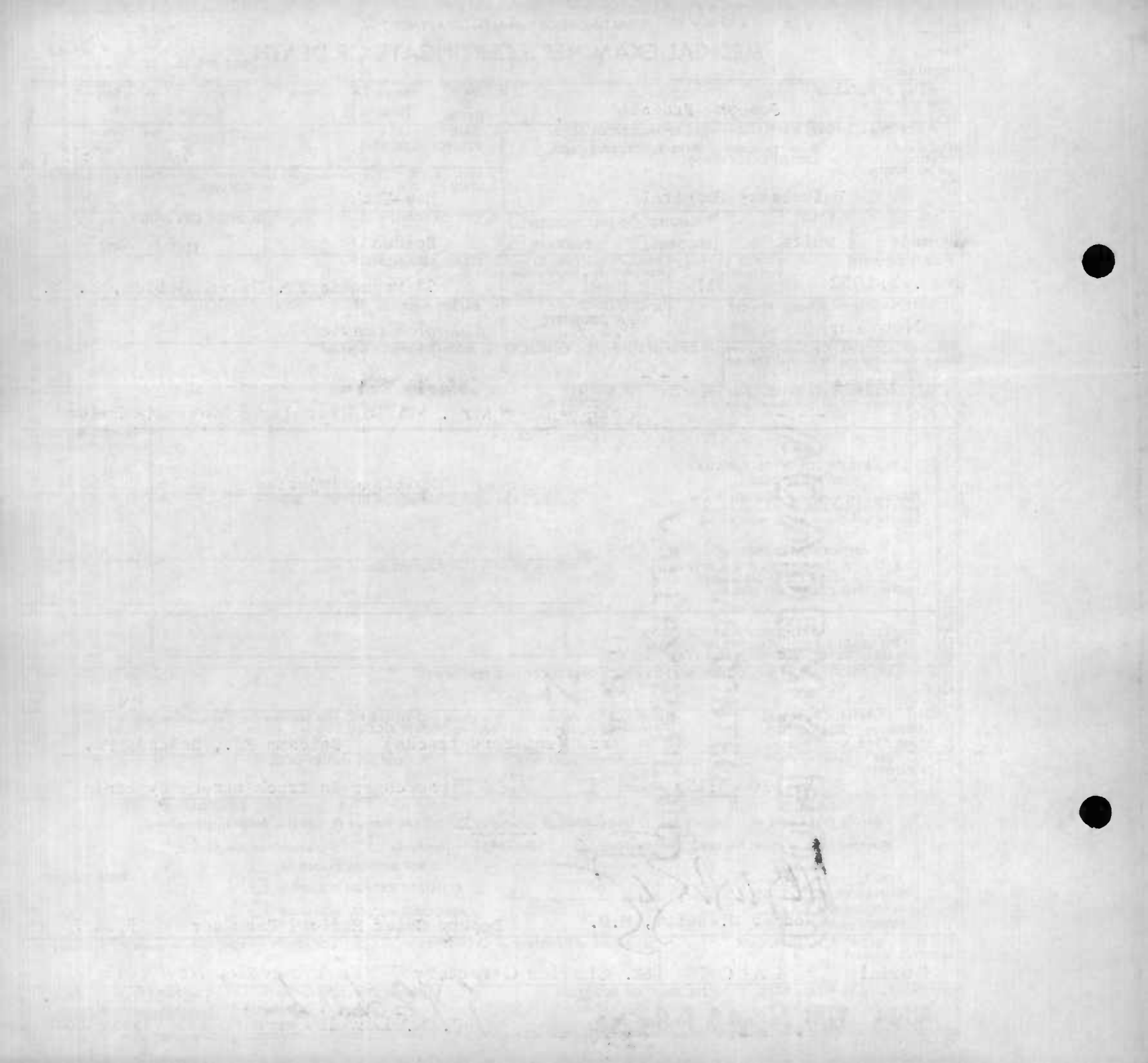


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

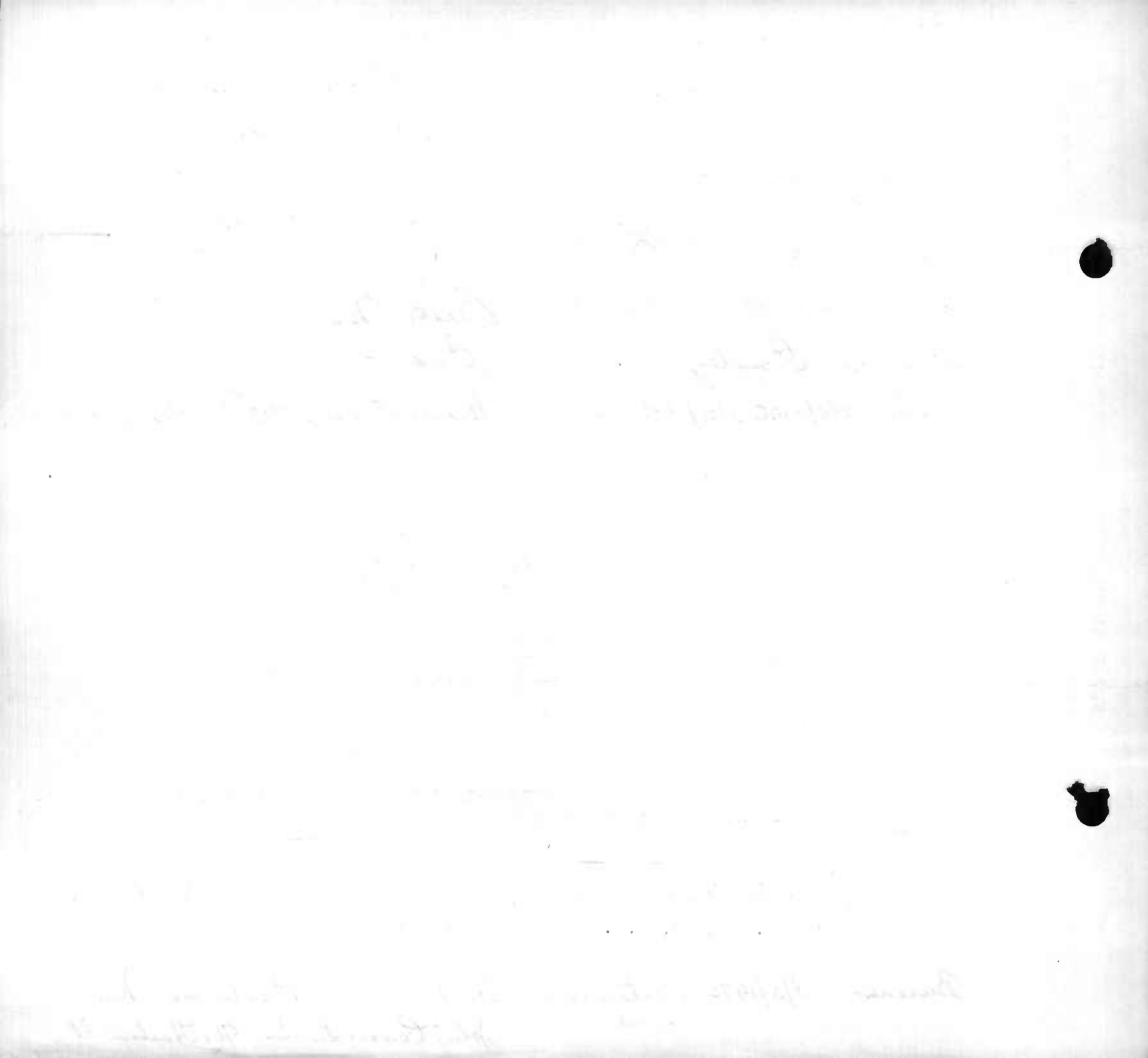
1. NAME OF DECEASED (Type or Print) Joseph Fragale				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 7 30 70 7:15 p.m.			
6. SEX male		7. RACE white		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE New York B. COUNTY V-29	
9. DATE OF BIRTH Nov. 3, 1952		10. AGE (In years last birthday) 17		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		14B. KIND OF BUSINESS OR INDUSTRY ---		13. FATHER'S NAME Joseph Fragale		15. MOTHER'S MAIDEN NAME Marie Tufano	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. Unknown		18. INFORMANT ADDRESS Mrs. Marie Fragale 98 Magnolia Drive			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				(A) IMMEDIATE CAUSE Multiple injuries DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) farm (railroad tracks)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Belcamp Rd., Belcamp Md. 6200			
22D. TIME OF INJURY (APPROX.) 7 29 70 5:15 p.m.		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? passenger in truck struck by train			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner DATE SIGNED 7/31/70							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4 AUG 70		24C. NAME OF CEMETERY or CREMATORY St. Charles Cemetery		24D. LOCATION (City, town, or county) (State) Farmingdale, New York	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR J. E. Lowell Lemmon ADDRESS Baltimore, Md. 243 Vista Road			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 7651	
1. NAME OF DECEASED (Type or Print) Everett W Ensley		2. DATE AND HOUR OF DEATH 1 August 1970 1:43 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital 3601 N Broadway		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 713 McHenry St - 21230			
5. SEX Male	6. RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/8/'07	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) city streetcleaner		10B. KIND OF BUSINESS OR INDUSTRY municipal		11. BIRTHPLACE (State or foreign country) Balt. Md.	
12. CITIZEN OF WHAT COUNTRY? US A		13. FATHER'S NAME George Ensley			
14. MOTHER'S MAIDEN NAME Eva -		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6/10/1945 to 3/21/1953			
16. SOCIAL SECURITY NO. -		17. INFORMANT Sharon Ensley - 713 McHenry St 21230			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Ventricular arrhythmia DUE TO, OR AS A CONSEQUENCE OF: (B) Myocardial disease Hypertensive Arteriosclerotic (C) Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 mins.	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 30 July 1970 to 1 August 1970 that (I) (we) last saw the deceased alive on 1 August 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gary M. Kammer, M.D.				23B. DATE SIGNED 1 August 1970	
23C. PHYSICIAN'S NAME (Type) Gary M. Kammer, M.D.				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/1970		24C. NAME OF CEMETERY OR CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970			
25B. NAME OF REGISTRAR Robert E. Jaber, M.D.		25C. FUNERAL DIRECTOR John J. Conner, Inc. 901 Hollins St.			



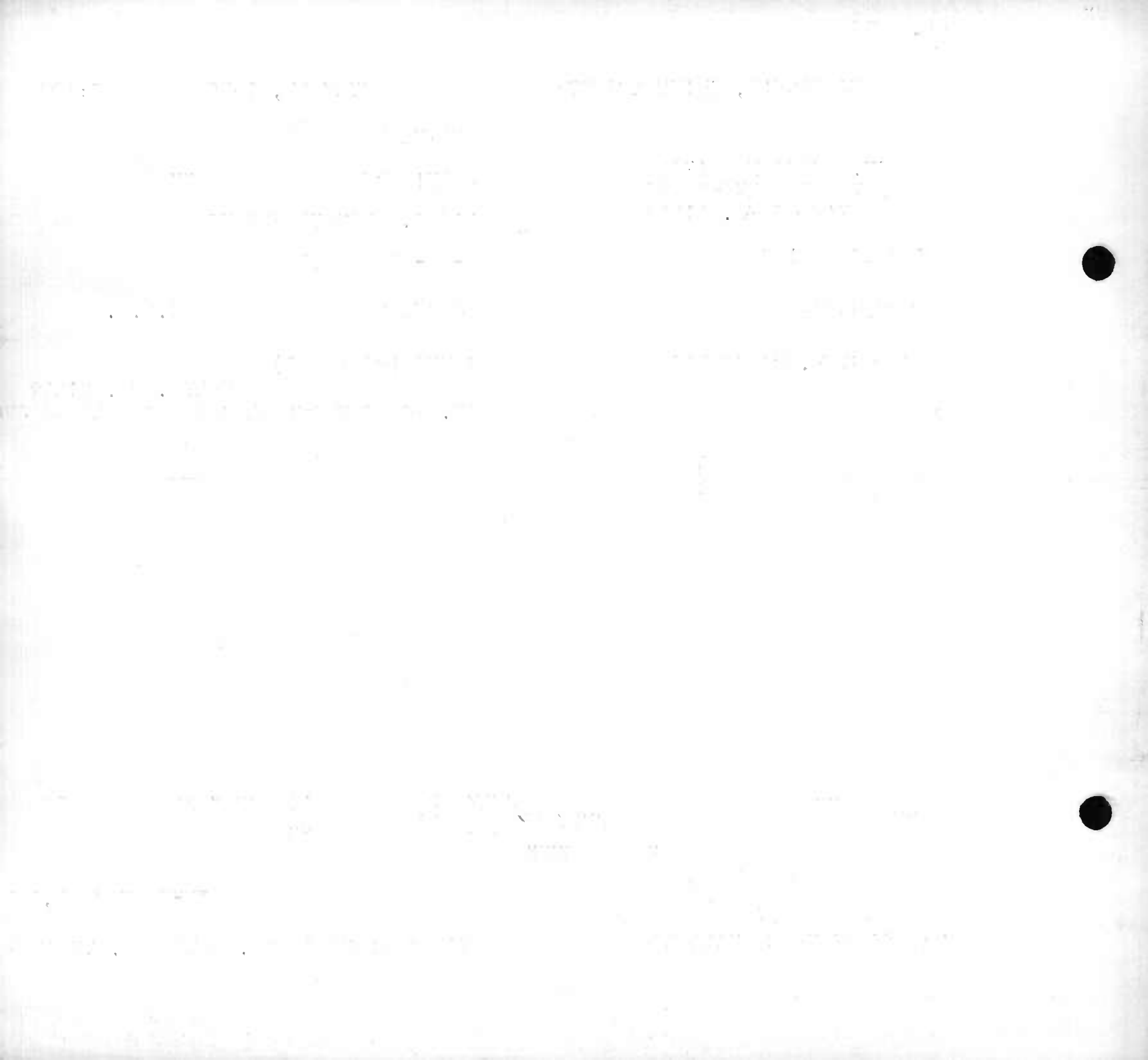
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-200 BIRTH NO. 70 7652		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH X Registered No. 70 7652	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Stanley Vocke		2. DATE AND HOUR OF DEATH 7/30/70 2:45 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore 5300	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould Convalesarium 6116 Belair Road Baltimore, Md. 21206		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Parkville D. STREET ADDRESS (If rural, give location) 1746 E. Joppa Road	
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH August 8, 1887
9. AGE (In years lost birthday) 82		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) Maryland
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George H. Vocke		14. MOTHER'S MAIDEN NAME Emma E. Simon	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 212-10-9378	17. INFORMANT Family records
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 009, 21 Acute Gastroenteritis		INTERVAL BETWEEN ONSET AND DEATH 4 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Acute Cerebral Thrombosis		7 days	
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the physician) attended the deceased from 11/17/1968 to 7/30/1970 , that (I) (was) last saw the deceased alive on 7/29/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.			
23A. SIGNATURE Albert B. Bradley		23B. DATE SIGNED 8/1/70	
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, M.D.		23D. ADDRESS 4900 Belair Road 21206	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-1-70	24C. NAME OF CEMETERY or CREMATORY St. Josephs Church Cemetery	24D. LOCATION (City, town, or county) (State) Cockeysville
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970	25B. NAME OF REGISTRAR John E. Taylor, M.D.	25C. FUNERAL DIRECTOR John Burns Sons Towson	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

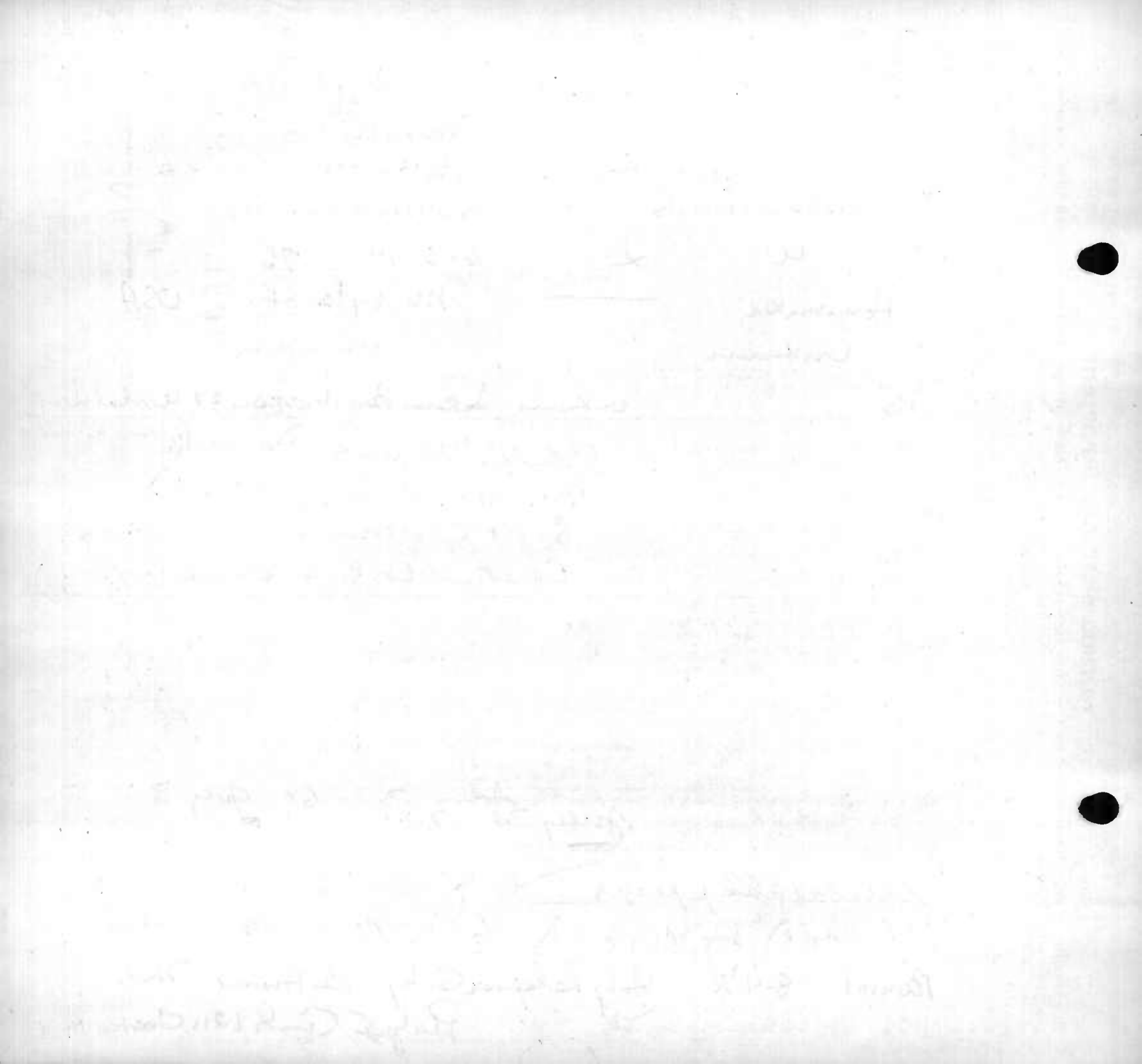
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 7653</u>	
BIRTH NO. <u>M-252</u>		70 7653			
1. NAME OF DECEASED (Type or Print) <u>MC KENZIE, EDITH LORETTA</u>			2. DATE AND HOUR OF DEATH <u>JULY 27, 1970</u> <u>5:10P M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. AGNES HOSPITAL</u> <u>40 CATON & WILKENS AVE</u> <u>BALTIMORE MD. 21229</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2008</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>216 S. AUGUSTA AVENUE</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>09-22-92</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>GEORGE W. MC KENZIE</u>			14. MOTHER'S MAIDEN NAME <u>CATHERINE (ELLS)</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>BALTO. MD. 21229</u> <u>ST. AGNES HOSPITAL CATON & WILKENS AVE</u>		
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial insufficiency</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u> <u>Pulmonary Infarct</u> <u>Pulmonary Edema</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>? years</u> <u>3 wks</u> <u>2 wks</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>none</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>JULY 04</u> 19 <u>70</u> to <u>JULY 27</u> 19 <u>70</u> that (1) (we) last saw the deceased alive on <u>JULY 27</u> 19 <u>70</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Perfecto C. Valarao</u>			23B. DATE SIGNED <u>XXX JULY 27, 1970</u>		
23C. PHYSICIAN'S NAME (Type) <u>DR. PERFECTO C. VALARAO</u>			23D. ADDRESS <u>CATON & WILKENS AVE. BALTO MD. 21229</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>7-30-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Catholic Cem</u>	
24D. LOCATION (City, town, or county) <u>Balto.</u>		24E. (State) <u>MD.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Farley L. Lavanagh</u>	
				ADDRESS <u>Robert E. Taylor, R.D.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7654	
<div style="display: flex; justify-content: space-between;"> B-623 70 7654 </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
FRANKES H. BERSTERMAN		July 31, 1970		7:45 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 1.2em;">90 Century Nursing Home Fayette and Peace Sts.</div>			A. STATE		
			B. COUNTY		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			800 N. Broadford St.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	6-3-94	76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker				Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Unknown			Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		Unknown		Jerome Bersterman 37 Woodlawn	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Cardiorespiratory Failure (A) IMMEDIATE CAUSE Due to, or as a consequence of: Hypertension - Art. CVD Gen + Cerebral Arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral Vascular Accident (CVA)		
			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Jan 3 1968 to July 31 1970, that (I) (we) last saw the deceased alive on July 31 1970 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
[Signature: William D. Appleberry] DEGREE					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
William D. Appleberry		6615 Reisterstown Rd			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8-4-70		Holy Redeemer Church	
				Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 4 1970		Robert E. Taylor, M.D.		Phyllis E. Coad 1211 Clontar Ave	

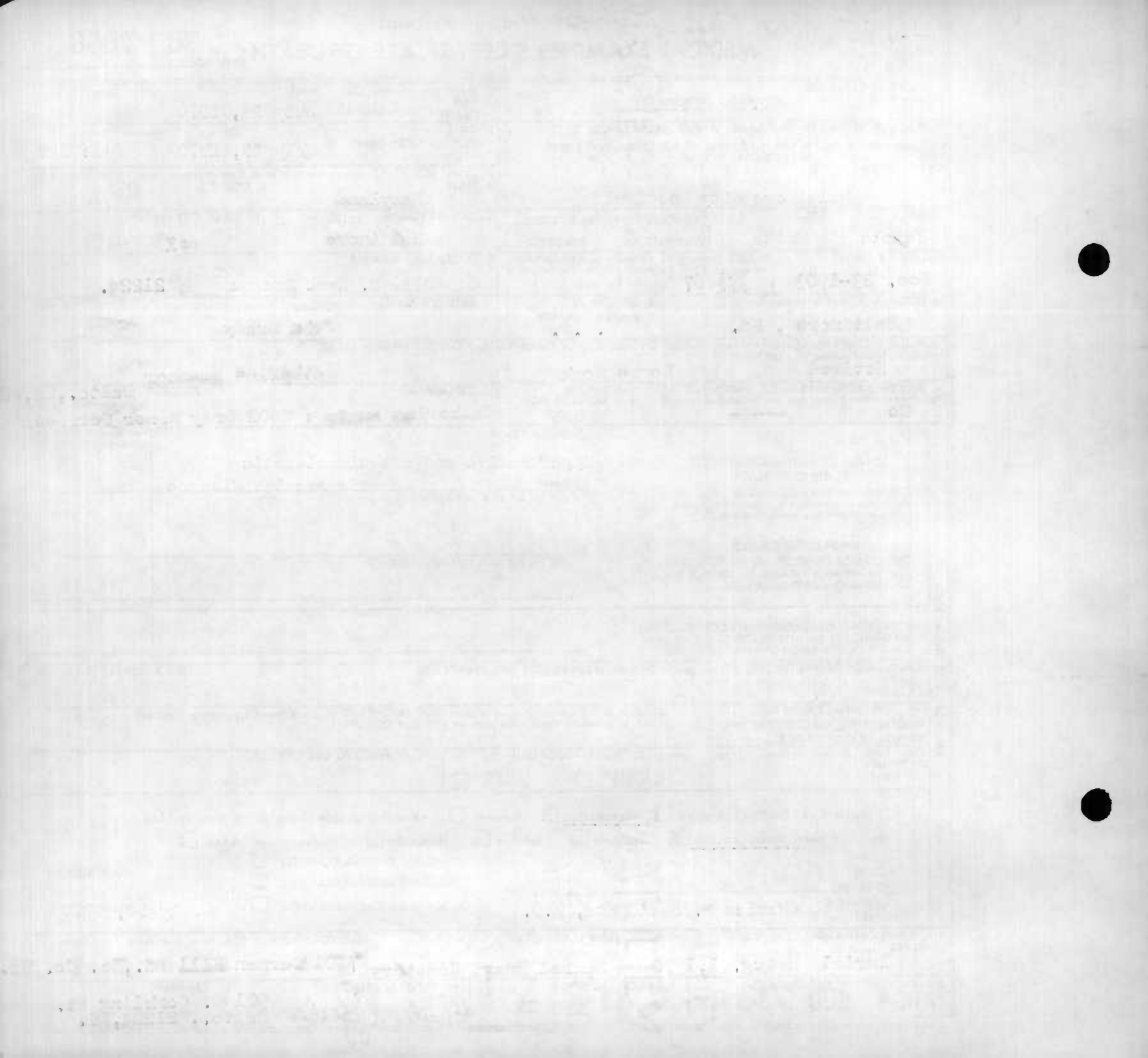


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

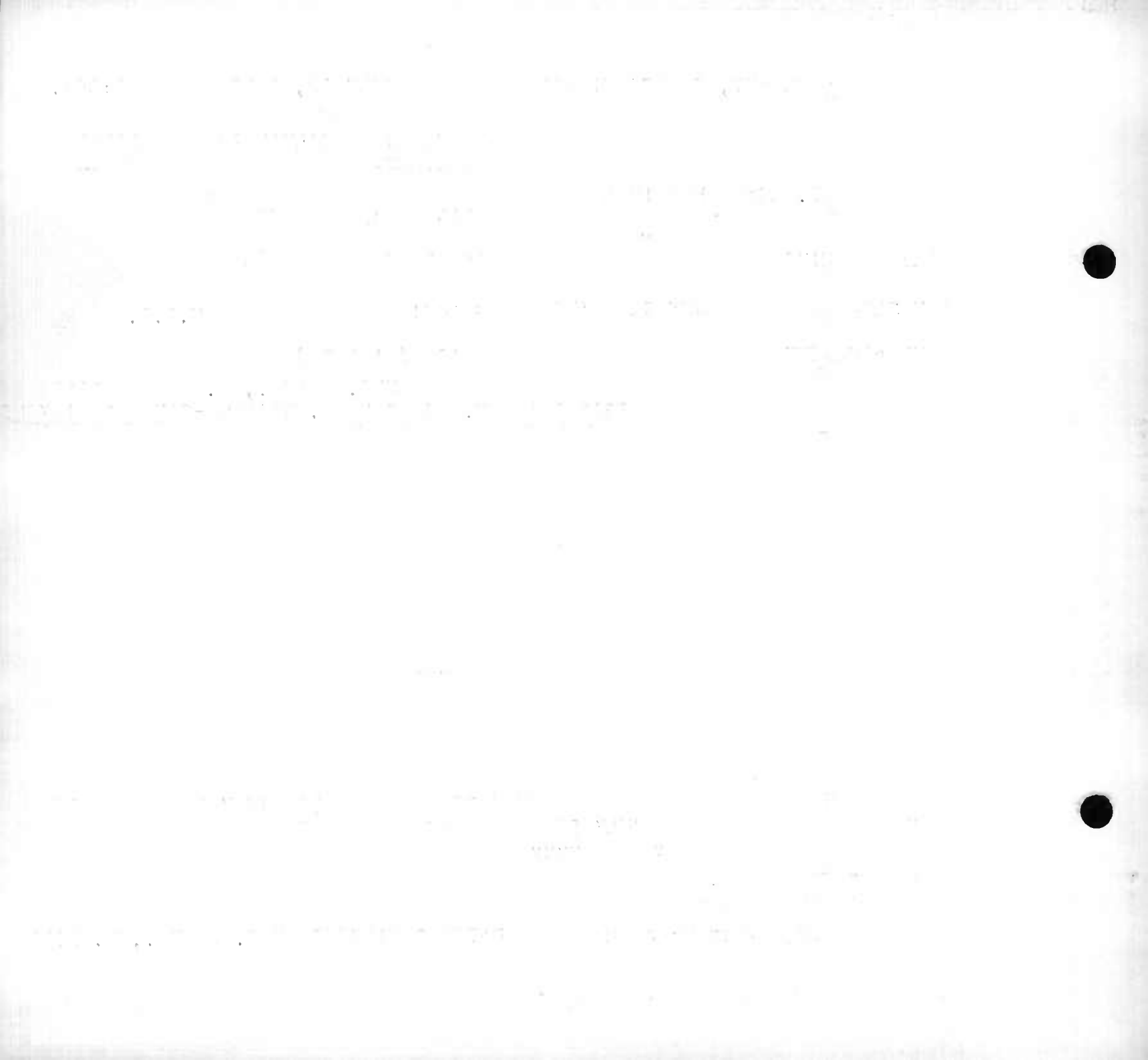
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 7655-	
BIRTH NO. S-660					
1. NAME OF DECEASED (Type or Print) SHROYER Elizabeth		2. DATE AND HOUR OF DEATH 7/29/70		0.43 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital of Baltimore		A. STATE Maryland		B. COUNTY 5600	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Lincoln		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 1 Sunflower Rd.					
5. SEX F	6. RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/07	9. AGE (in years last birthday) 65	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Theodore Snyder		14. MOTHER'S MAIDEN NAME Nora McNeil			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. noen		17. INFORMANT Family records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Granuloma of the lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 7/29/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 7/12/70 19 to 7/29/70 19 that (we) last saw the deceased alive on 7/29/70 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Josquin Puig-Antich		23B. DATE SIGNED 7/29/70		23C. PHYSICIAN'S NAME (Type) Josquin Puig-Antich	
23D. ADDRESS Sinai Hospital Balto. Md. 21215		23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial transit 7-31-70		24B. DATE 7-31-70		24C. NAME OF CEMETERY or CREMATORY Tyrone Cemetery	
24D. LOCATION (City, town, or county) (State) Tyrone Pennsylvania		25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John Burns Sons		25D. ADDRESS Town	

BIRTH NO.		REG. NO.	
H-155 70 7656		70 7656	
BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
HELEN HOFFMAN		Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 29, 1970	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD	
31 Baltimore City Hospital		Month Day Year July 29, 1970	
6. SEX		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Female		A. STATE Maryland	
7. RACE		B. COUNTY	
White		2611	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN	
		Baltimore	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS?	
Dec. 23-1903		YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (in years, last birthday)		E. STREET AND NUMBER	
67		717 S. East Avenue # 21224.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Baltimore, Md.		U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		13. FATHER'S NAME	
Retired		John Brady	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
House Work		Catherine Snencer	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, near or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
No		NONE	
18. INFORMANT		ADDRESS	
Catherine Amato : 2602 Gray Manor Terrace		Balto., 22, Md.	
19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Hypertensive and arteriosclerotic	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		21. AUTOPSY? (Yes or No)	
0		No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Charles S. Springate, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)		DATE SIGNED	
Burial		July 30, 1970	
24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Aug. 1, 1970		Sacred Heart Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR, ADDRESS	
7401 German Hill Rd., Ba. Co., Md.		901 S. Conkling St. Balto., 21224, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
AUG 4 1970		Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR, ADDRESS			
Charles S. Springate			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FBD		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7657	
P-453		70 7657		70 7657	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		POULNOTT, GEORGE WILLIAM		JULY 30, 1970 1:30A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		5. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND BALTIMORE 21227 1401	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER		1313 LINDEN AVENUE	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10 07 00	69	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
DRY CLEANER		DRY CLEANING		GEORGIA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JOHN POULNOTT		ALICE (WILLARD)		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
		232122181		AVES. BALTO., MD. ADDRESS 21229	
				ST. AGNES HOSP. RECORDS-CATON & WILKENS	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Pneumonia 12 hours	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO, OR AS A CONSEQUENCE OF:		Arteriosclerosis	
ANTECEDENT CAUSES		(C) DUE TO, OR AS A CONSEQUENCE OF:		ASCVD	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from JULY 25 19 70 to JULY 30 1970		that (I) (we) lost saw the deceased alive on JULY 30 19 70		and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED			
Paulo Westphalen MD		7/30/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
PAULO WESTPHALEN MD		CATON & WILKENS AVES. BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		Aug 4 1970		Landon Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 4 1970		Robert E. Feltz		ADDRESS 1348 Sulphur Spring Rd	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		70 7658		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 7658	
1. NAME OF DECEASED (Type or Print) Woodrow W. Myers				2. DATE AND HOUR OF DEATH 8/1/70 11250 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 31 4940 Eastern Avenue Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore 5300			
				C. CITY OR TOWN Edgemere		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 2108 Oak Road #21219			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-7-17	9. AGE (in years last birthday) 53	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bethlehem Steel Co.			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Benjamin Myers				14. MOTHER'S MAIDEN NAME Rebecca Dillon			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1935-1941			16. SOCIAL SECURITY NO. 243-18-8588		17. INFORMANT Records: Baltimore city Hospitals 4940 Eastern Avenue #21224		
18. 2910 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Klebsiella pneumoniae DT's (B) DUE TO, OR AS A CONSEQUENCE OF: Pancreatitis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 5 days 7 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-26 19 70 to 8-1-70 19 70 that (I) (we) last saw the deceased alive on 8-1-70 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William W. MacDonald				23B. DATE SIGNED 8/1/70		23C. PHYSICIAN'S NAME (Type) William MacDonald M.D.	
23D. ADDRESS Baltimore city Hospitals 4940 Eastern Avenue #21224							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/4/70		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR John J. Duda, M.D.		25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE AMENDED

BIRTH NO. <u>70-13804</u> <u>70</u> <u>7659</u>		BALTIMORE CITY HEALTH DEPARTMENT REG. NO. <u>70</u> <u>7659</u>	
1. NAME OF DECEASED (Type or Print) <u>BABY BOY KNUTSON, DON WILLIAM</u>		2. DATE AND HOUR OF DEATH <u>7-31-70</u> <u>345</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>CHURCH HOME & HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>53-00</u>	
FULL NAME OF DECEASED (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>39</u>		C. CITY OR TOWN <u>BALTIMORE</u>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>100 N. Broadway</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH <u>7-30-70</u>	9. AGE (In years last birthday) <u>4</u> <u>15</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>OLIVER KNUTSON</u>		14. MOTHER'S MAIDEN NAME <u>KAREN SMITH</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>PARENT</u> ADDRESS <u>1913 Tolson Ave.</u>
18. <u>77691</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Intracranial Hemorrhage</u> 4 hrs. (B) <u>Pulmonary Atelectasis, Bilateral</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>2</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/30</u> 19 <u>70</u> to <u>7/31/70</u> 19 <u>70</u> and that (I) (we) last saw the deceased alive on <u>7/31</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Honorable M. Braggins, M.D.</u>		23B. DATE SIGNED <u>7/31/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. FETTER</u>		23D. ADDRESS <u>100 N. Broadway St. Baltimore, MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>8-3-70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>BEAR RIVER CEM.</u>	24D. LOCATION (City, town, or county) (State) <u>BEAR RIVER CITY, UTAH</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1970</u>	25B. NAME OF REGISTRAR <u>Robert E. Jarboe, M.D.</u>	25C. FUNERAL DIRECTOR <u>W. Braggins, M.D.</u> ADDRESS <u>31222</u>	

Letter from Medical Record Librarian at Church Home & Hospital re given name of
child dated 8/19/70

1913 Lebanon Ave

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-512		70 7660		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7660	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) THOMPSON, DELIA A				2. DATE AND HOUR OF DEATH JULY 30, 1970 3:50P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2551			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 819 Unetta Avenue			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-16-1904	9. AGE (In years last birthday) 65	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) IRELAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME THOMAS NELSON			
14. MOTHER'S MAIDEN NAME MARGARET (NEE ROGERS) NELSON				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 218-01-3107				17. INFORMANT Mr. Charles M. Thompson, 8072 Phirne Rd. 21061			
18. 43691 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE CVA, Coma DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JULY 20 19 70 to JULY 30 19 70 and that (I) (we) last saw the deceased alive on JULY 30 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ching-Hui Tsai M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/30/70	
23C. PHYSICIAN'S NAME (Type) Ching-Hui Tsai M.D.				23D. ADDRESS BALTIMORE, MD 21229 ST. AGNES HOSP; CATON & WILKENS AVES.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-3-1970		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 70 7661	
5-562 70 7661		BIRTH NO.		1. NAME OF DECEASED (Type or Print) Rachael Elizabeth Smorgens		2. DATE AND HOUR OF DEATH 10:40pm 7-30-70	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GEN HOSP. 3001 S. HANOVER ST.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 2553 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2203 LANGLEY ST.			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-12-92	9. AGE (In years lost birthday) 77	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		
11. BIRTHPLACE (State or foreign country) BELGIUM				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ? Keersbilk ? KERISBELT (dec.)				14. MOTHER'S MAIDEN NAME SYLVIA ? (dec)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. XXXXXXXXXX			
17. INFORMANT Mr. Edmond Smorgens, 2203 Langley St.				18. CAUSE OF DEATH CARDIAC ARREST CONGESTIVE HEART FAILURE WITH CHRONIC ATRIAL FIBRILLATION			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7:30 : 1970 to 7:30 1970, that (I) last saw the deceased alive on 7:30 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) did not view the body after death.							
23A. SIGNATURE C.C. Ugorji MD.				23B. DATE SIGNED 7:30:70			
23C. PHYSICIAN'S NAME (Type) C.C. UGORJI MD				23D. ADDRESS South Baltimore Gen Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-3-1970		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970				25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	

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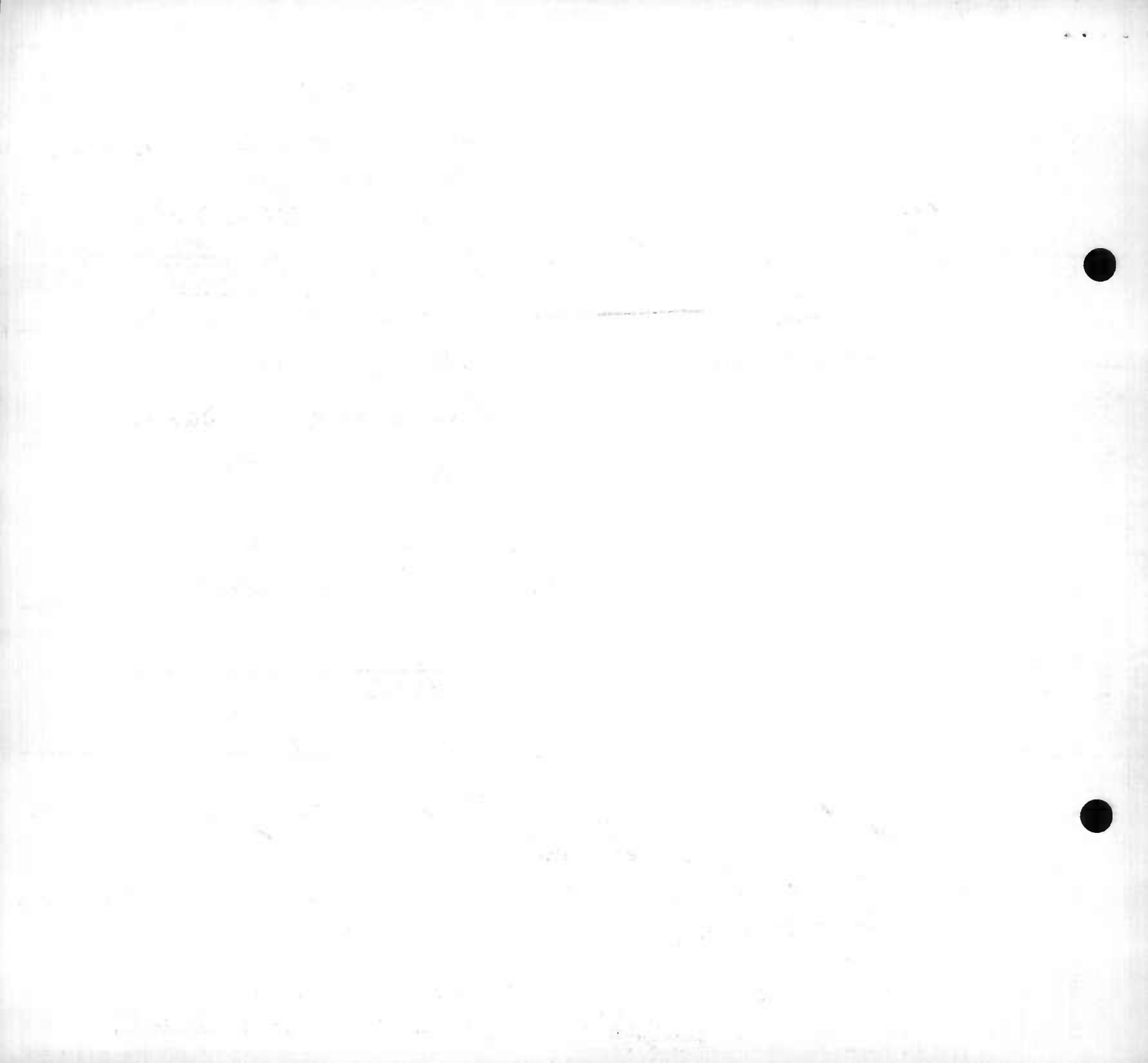
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

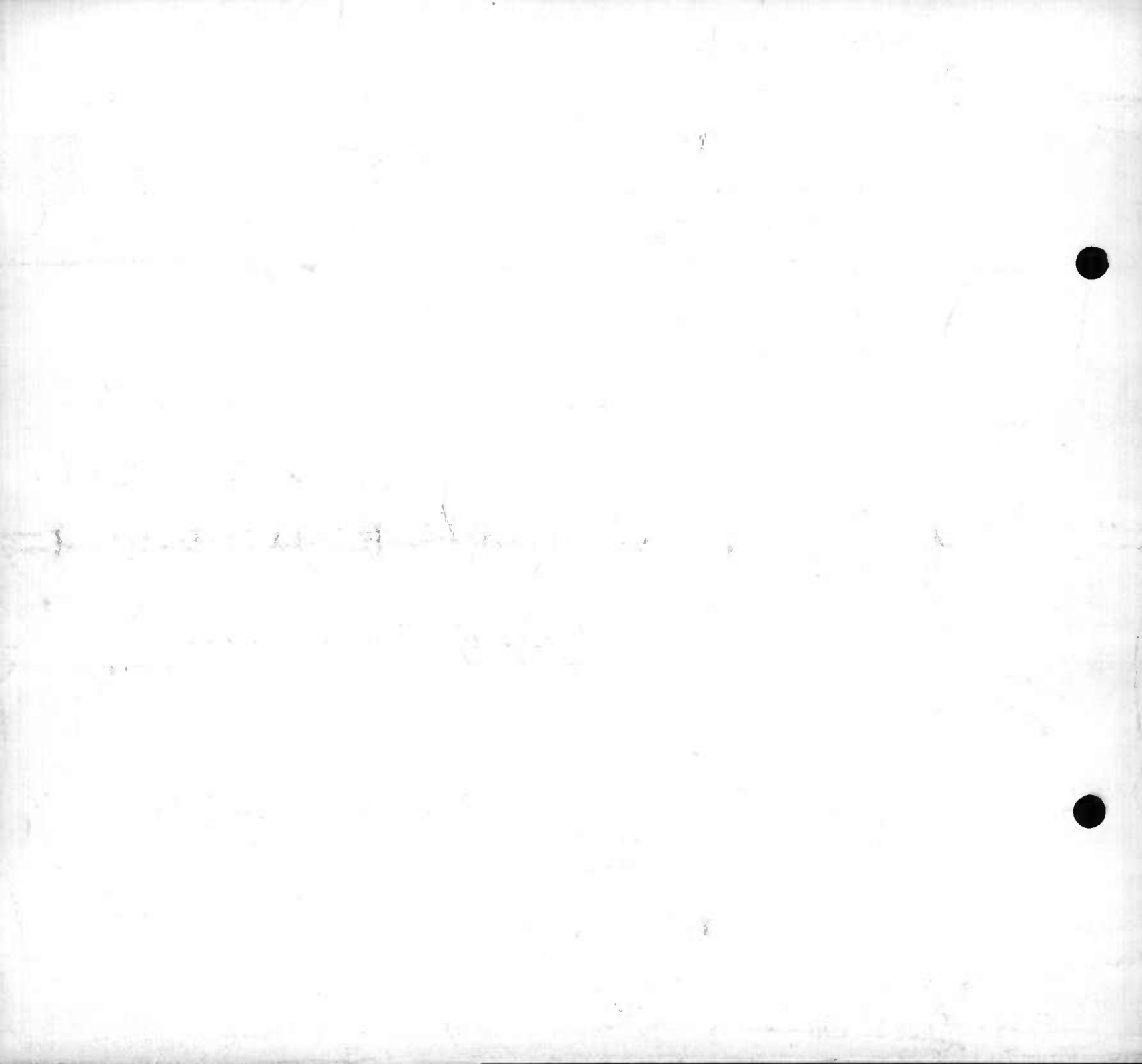
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 7662</u>	
1. NAME OF DECEASED (Type or Print) <u>LARSON, OSCAR C.</u>		2. DATE AND HOUR OF DEATH <u>7-29-70</u> <u>7:29 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNION MEMORIAL HOSPITAL</u> <u>44</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3344 CHESTECFIELD AVE.</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-5-02</u>	9. AGE in years (last birthday) <u>67</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Work</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN SELF</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>AUGUST LARSON</u>			
14. MOTHER'S MAIDEN NAME <u>MALTZ, MARGARET</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Jane H. Larson - Same</u> ADDRESS			
18. <u>4-27-21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>BRAIN DAMAGE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CARDIOGENIC SHOCK</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>SEC TO CARDIAC ARREST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOBY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>July 21,</u> 19 <u>70</u> to <u>July 29,</u> 19 <u>70</u> that (I) <u>yes</u> last saw the deceased alive on <u>July 29,</u> 19 <u>70</u> and that (in my) <u>yes</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>yes</u> (did) <u>yes</u> view the body after death.					
23A. SIGNATURE <u>J. P. Mikus M.D.</u>		23B. DATE SIGNED <u>07/29-70</u>		23C. PHYSICIAN'S NAME (Type) <u>J. P. MIKUS M.D.</u>	
23D. ADDRESS <u>UMH</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>8-1-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cm.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>John C. Miller Inc. 6415 Belair Rd.</u> ADDRESS	



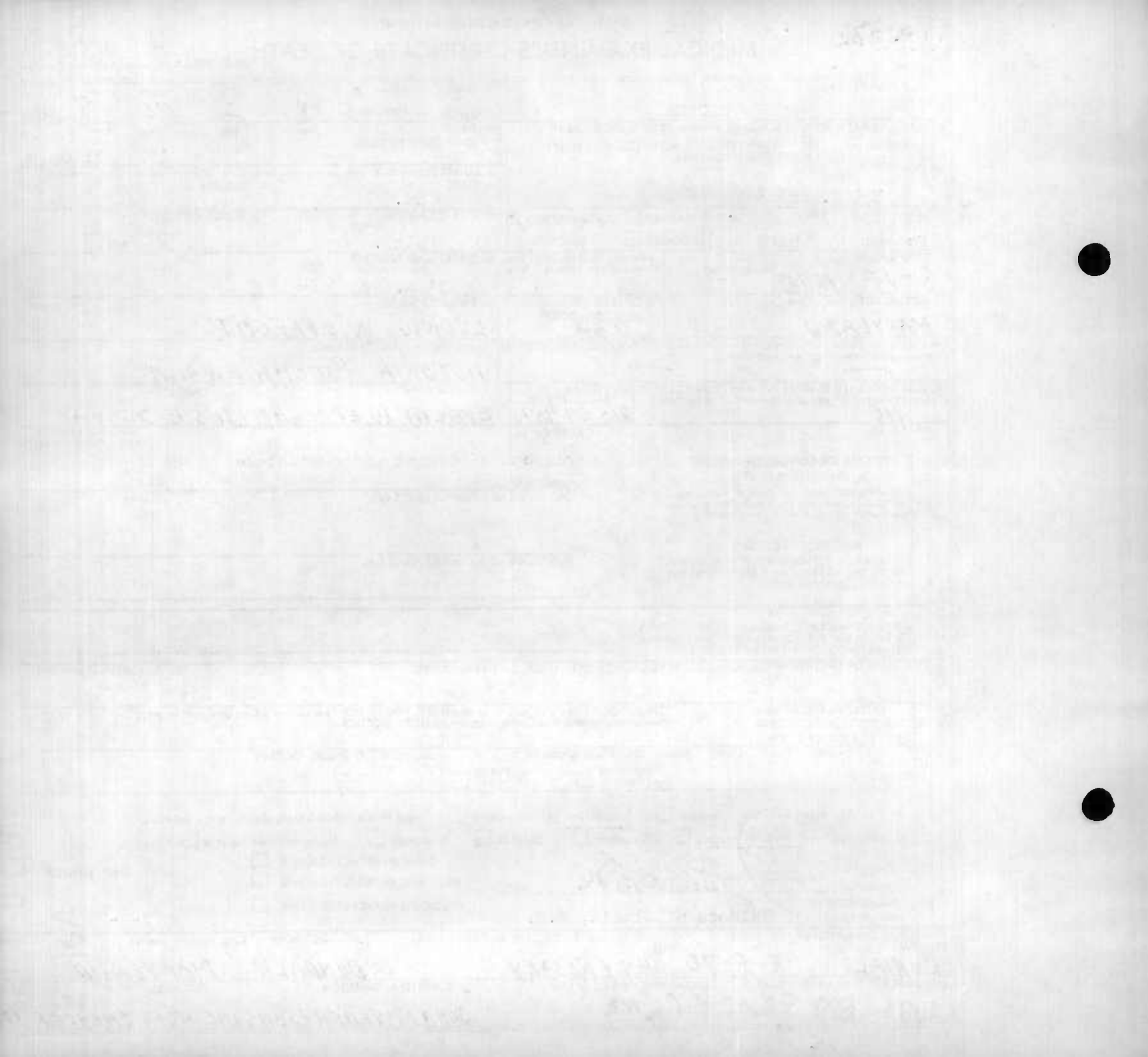
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 70 7663	
T-250 70 7663		BIRTH NO.		70 7663		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) VERA MARIE TESONE				2. DATE AND HOUR OF DEATH 7/31/70 2:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNIV. OF MARYLAND 38 HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND		B. COUNTY Harford	
				C. CITY OR TOWN ABERDEEN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> ? <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER HUNTER HOTEL			
5. SEX F.M.	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1899	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer for Homberger Atlantic City			10B. KIND OF BUSINESS OR INDUSTRY Phila. Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frank DeRogatis				14. MOTHER'S MAIDEN NAME Rosina Lama			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 164-10-3661A		17. INFORMANT ADDRESS Mrs. Joseph Neff Hotel Hunter Aberdeen			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 599.01 + 209X				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myxo Negative deprecis (B) Urinary Tract infections (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Myeloproliferative syndrome							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/13 19 70 to 7/31 19 70 that (I) (we) last saw the deceased alive on 7/31 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Louis S. Dwyer				23B. DATE SIGNED 7/31/70		23C. PHYSICIAN'S NAME (Type) Robert E. Taylor, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 7/31/70		24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.		24D. LOCATION (City, town, or county) (State) Phila. Pa.	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Loring Byers		25D. ADDRESS 8728 Liberty Rd. Randallstown, Md.	



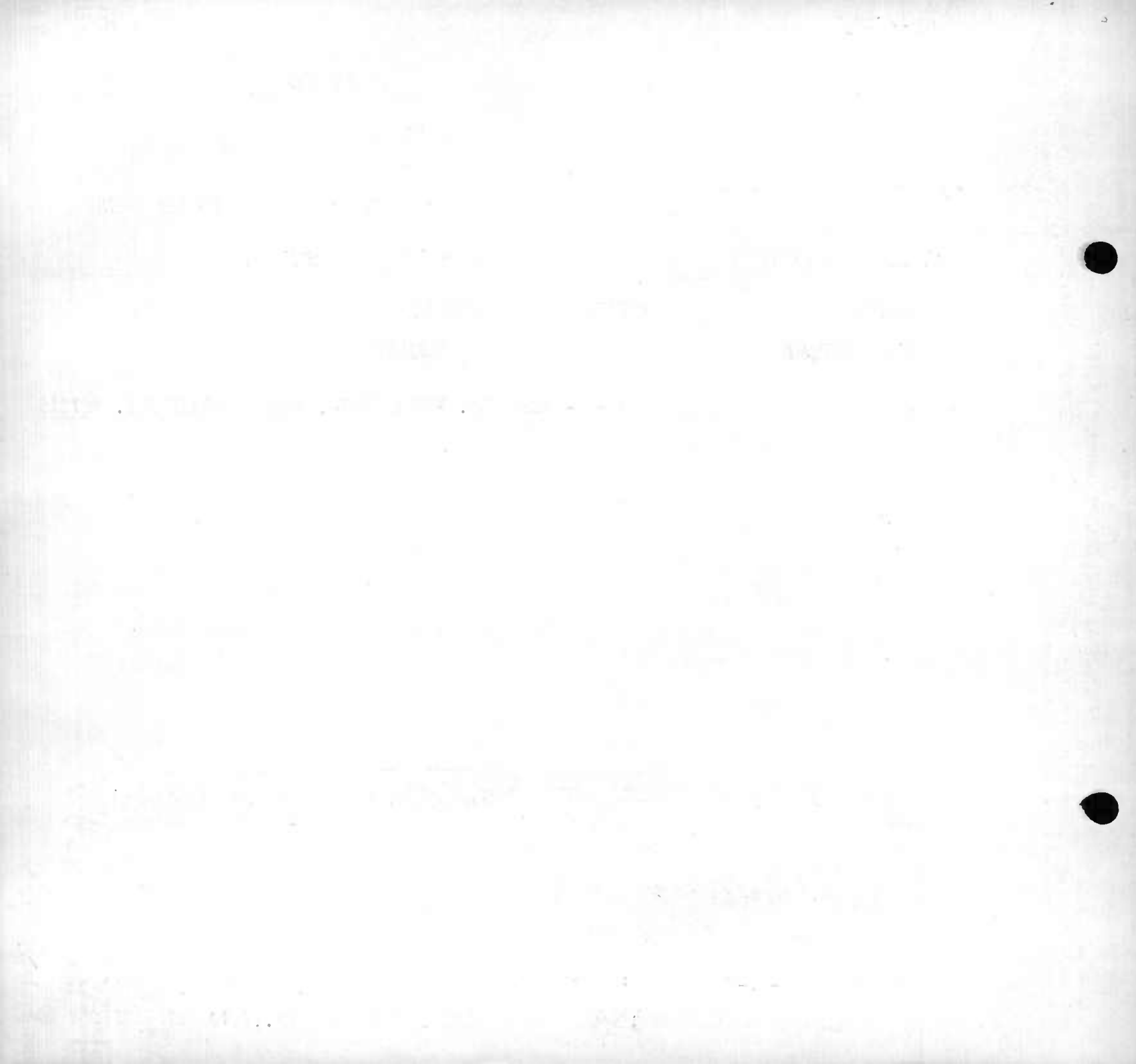
BIRTH NO.		REG. NO.	
W-362		70 7664	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
MARY WIETRECHT		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD	
00 131 S. Broadway		Month Day Year Hour	
6. SEX		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
Female		A. STATE B. COUNTY	
7. RACE		C. CITY OR TOWN	
White		Balto.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS?	
9. DATE OF BIRTH		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8-15-1895			
10. AGE (In years last birthday)		E. STREET AND NUMBER	
74		131 S. Broadway	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
MARYLAND		USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		13. FATHER'S NAME	
		LUDWIG WIEPRECHT	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
		VICTORIA PROCHNIEWSKA	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
NO		215 09 9895	
18. INFORMANT		ADDRESS	
EVELYN WIEPRECHT		131 S. BROADWAY	
19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Carcinoma of breast with metastases	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE	
DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No)		no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Isidore Mihalakis, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
BURIAL		8-5-70	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
HOLY ROSARY		DUNDALK MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
AUG 4 1970		Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	
JOHN M. WEBER & SONS INC		401 S. CHESTER ST	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

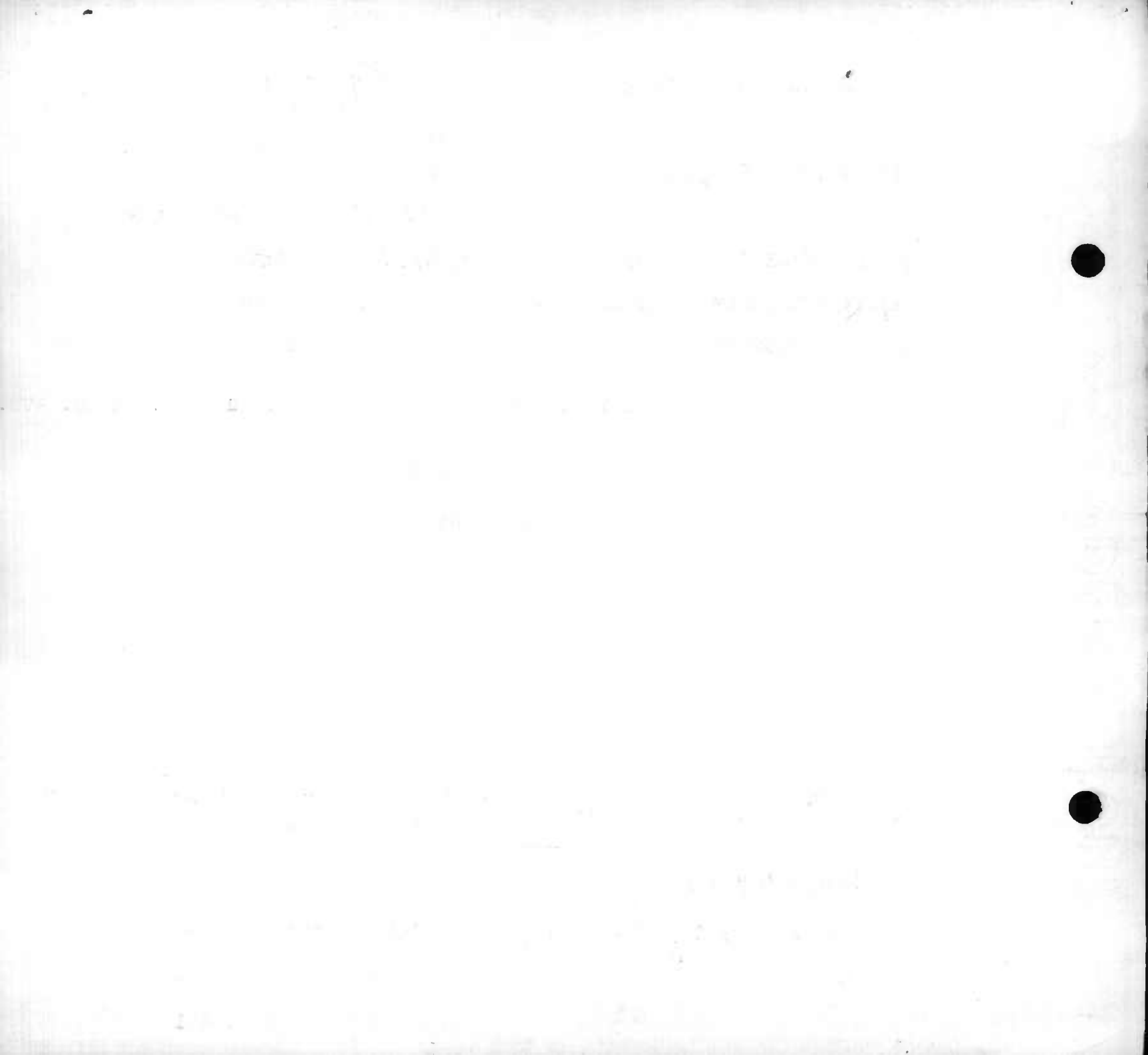
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7665	
BIRTH NO. W-536 70 7665				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) JOSEPH WEINTRAUB			2. DATE AND HOUR OF DEATH 7.27.70 12¹⁰ PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 9 LEVINDALE HEBREW HOME			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER XXXXXXXXXXXX 5800 MERVILLE AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-89	9. AGE (In years lost birthday) 80 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCER		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME SOL WEINTRAUB			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-32-0022A		17. INFORMANT MRS. PEARL LEVIN, 5800 MERVILLE AVE. #21215	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 5-99.0 (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH SEPTIC SHOCK (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: URINARY TRACT INFECTION (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan 1963 19 to July 27, 1970 19 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 27.70 19 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE M. Bodenheimer, M.D.				23B. DATE SIGNED 7.27.70	
23C. PHYSICIAN'S NAME (Type) M. BODENHEIMER, M.D.				23D. ADDRESS Sinai Hospital.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-28-70		24C. NAME OF CEMETERY or CREMATORY SWINICHER WOLINER BENEVOLENT SOCIETY, BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Fisher, Jr.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6090 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 7666</u>	
G-432 70 7666					
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>SARA GOLDSTEIN</u>	
2. DATE AND HOUR OF DEATH <u>7/28/90</u> <u>10:42 P.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2720</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSP. OF BALTO.</u>				C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>6204 Park Heights Ave.</u>					
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/24/95</u>	9. AGE (In years last birthday) <u>45</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>MORRIS HONKOFKY</u>				14. MOTHER'S MAIDEN NAME <u>MINNIE RICHMAN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>381-03-7673</u>	
17. INFORMANT <u>MRS. IRENE AUSTER, 6204 PK. HGHTS. AVE.</u>				ADDRESS	
18. <u>410.91</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>he</u> (this hospital) attended the deceased from <u>7/28</u> 19 <u>70</u> to <u>7/28</u> 19 <u>70</u> that <u>we</u> last saw the deceased alive on <u>7/28</u> 19 <u>70</u> and that <u>in my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>Fortunato V. Elizaga</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>FORTUNATO V. ELIZAGA</u>				23D. ADDRESS <u>SINAI HOSP. BALTO.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7-30-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN</u>	
ADDRESS					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>8-265</u>		70 7667		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 7667</u>	
1. NAME OF DECEASED (Type or Print) <u>Sadie B. Sackerman</u>				2. DATE AND HOUR OF DEATH <u>7-30-70</u> <u>12:35 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Levindale HEBREW HOME</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2720</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>XXXXXXX</u> <u>7018 PARK HEIGHTS AVE.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-31-83</u>	9. AGE (In years last birthday) <u>87</u>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 1 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ISRAEL SAMUEL BERLINER</u>				14. MOTHER'S MAIDEN NAME <u>HANNAH LANGOOD</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-10-4618D</u>		17. INFORMANT <u>MR. BERNARD KUDER</u> ADDRESS <u>4405 VESTA AVENUE #21207</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>of ce Multiple Metastasis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Co of left breast</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Atherosclerotic Cardiovascular</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u> <u>years</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6-4</u> 19 <u>70</u> to <u>7-30</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>7-30</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ruben Drizanski MD</u>				23B. DATE SIGNED <u>7/30/70</u>		23C. PHYSICIAN'S NAME (Type) <u>RUBEN DRIZANSKI MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7-31-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HEBREW FRIENDSHIP</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN</u>			



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 7668

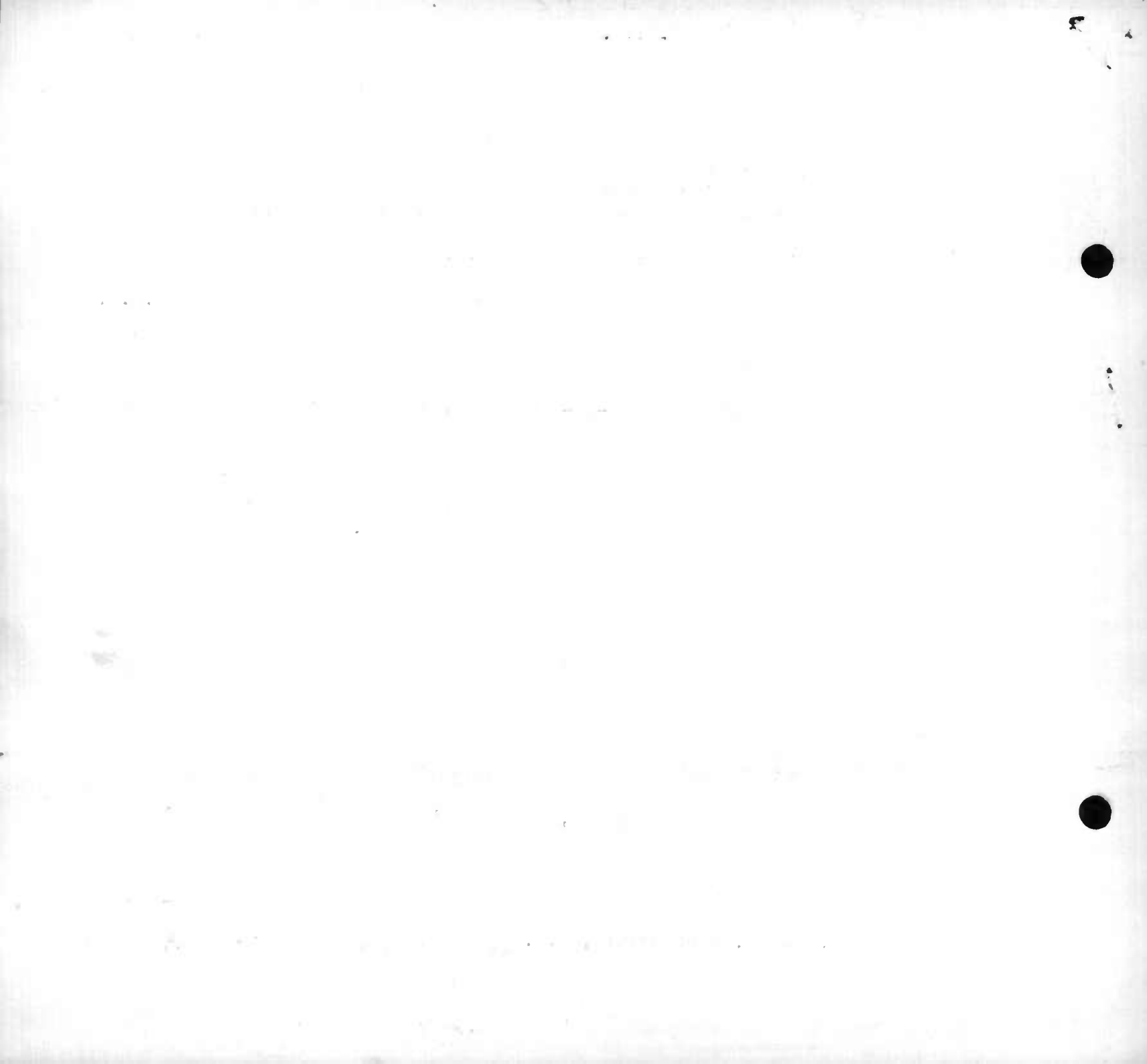
BIRTH NO.

1. NAME OF DECEASED (Type or Print) JEROME BECKMAN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> July 30, 1970		Month Day Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2014 Harford Rd.		3. DATE PRONOUNCED DEAD July 30, 1970		Month Day Year	Hour 9:15 A.M.
6. SEX Male		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH SEPT. 27, 1910		10. AGE (In years lost birthday) 59		11. BIRTHPLACE (State or foreign country) PHILADELPHIA, PA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HARRY BECKMAN		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMANAGER	
15. MOTHER'S MAIDEN NAME ANNA ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 39-03-0780	
18. INFORMANT MRS. ELLA BECKMAN, 3101 BANCROFT RD.		19. CAUSE OF DEATH Asphyxia		20. DATE OF OPERATION 7-30-70	
21. AUTOPSY? (Yes or No) No		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Store		23. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 2014 Harford Rd.	
24. TIME OF INJURY (APPROX.) 7-30-70		25. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		26. HOW DID INJURY OCCUR? Hanged self	
27. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
28. ACTUAL SIGNATURE <i>Charles S. Springate</i> EXAMINER'S NAME (Type) Charles S. Springate, M.D.		29. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		30. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
31. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		32. DATE SIGNED 7-30-70		33. 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	
34. DATE REC'D BY HEALTH DEPT. AUG 4 1970		35. NAME OF REGISTRAR Valerie E. [Signature]		36. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO	
37. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC		38. ADDRESS 6010 Reisterstown Road		39. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

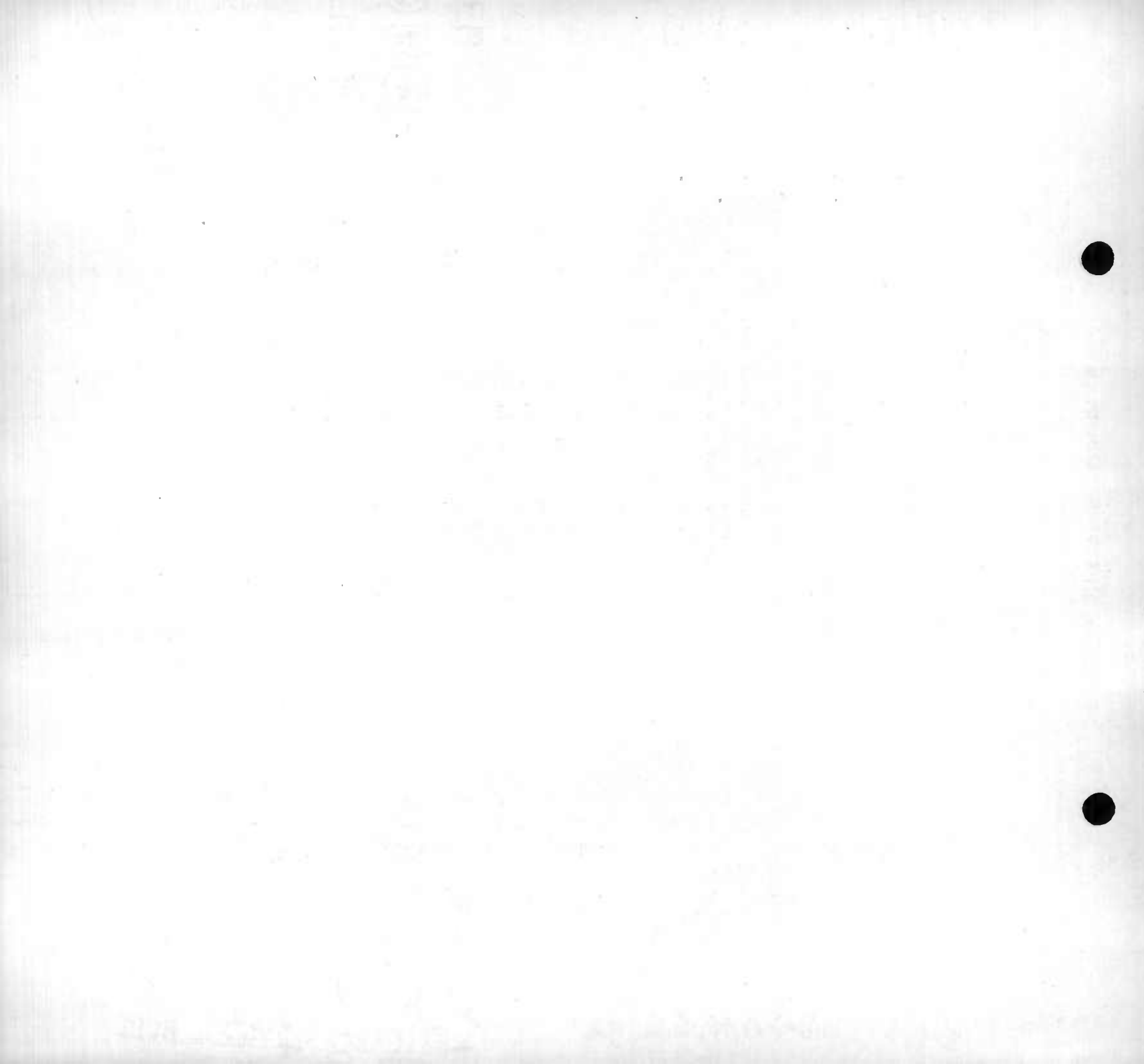
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7669	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 8-650 70 7669 </div>					
1. NAME OF DECEASED (Type or Print) Brown, Bessie			2. DATE AND HOUR OF DEATH 7-29-70 4:45 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital 1514 Division Street Baltimore, Maryland 21217			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1701 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 607 Pennsylvania Avenue		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-4-1888	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY U.S.A.			13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 217-54-0676			17. INFORMANT Elouise Mitchell ADDRESS 607 Herce Street		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSE DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Fracture neck of femur (Rt) (B) DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (C)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days days					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CONGESTIVE HEART FAILURE AND RENAL FAILURE					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NURSING HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 607 PENNSYLVANIA AVE			
21D. TIME OF INJURY (APPROX) 7-10-70 (?)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FELL FROM CHAIR	
22. I certify that (I) (this hospital) attended the deceased from July 10, 1970 to July 29, 1970 that (I) (we) last saw the deceased alive on July 29, 1970 and that (in my) (our) opinion death occurred on the date July 29, 1970 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Madhan D. Barhanpurka M.D.				23B. DATE SIGNED 7-30-70	
23C. PHYSICIAN'S NAME (Type) Madhan D. Barhanpurka, M.D.				23D. ADDRESS 1100 N. Street, Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-31-70		24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970 25B. NAME OF REGISTRAR Robert E. Taylor, R.D.			
25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7670
BIRTH NO. M-324 70 7670		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Maria MITCHELL		2. DATE AND HOUR OF DEATH 7/30/70 3:25 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CENTURY HOME, Inc. 102 N. Paca St. Balto Md 21201		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1606 C. CITY OR TOWN Balto D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 520 Poplar Grove St. 21223		
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/15/81 9. AGE (In years last birthday) 89 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219 30 8312	17. INFORMANT ADDRESS	
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardio Respiratory Failure massive Cerebral Hemorrhage Hypertensive Art. CVD Gen & Cerebral Atherosclerosis				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from June 18 1970 to July 30 1970 , that (I) (we) last saw the deceased alive on July 30 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.				
23A. SIGNATURE William D Applefenz DEGREE				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) William D Applefenz D				23D. ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-31-70		24C. NAME OF CEMETERY AND LOCATION (City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-323 70 7671		BALTIMORE CITY HEALTH DEPARTMENT		70 7671	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) BATHGATE, RAYMOND E			2. DATE AND HOUR OF DEATH 7/30/70 12:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5542 ASHBOURNE RD		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 19 05	9. AGE (in years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY RAILWAY EXPRESS		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME JOHN BATHGATE		
14. MOTHER'S MAIDEN NAME AGNES HESSIAN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 212 01 2408			17. INFORMANT & CATON BALTO MD 21229 8 ST AGNES HOSPITAL RECORDS, WILKENS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 16211 I METASTATIC BRONCHOGENIC CARCINOMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN		
19A. DATE OF OPERATION 0 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 7/16/1970 to 7/30/1970 that (X) (we) last saw the deceased alive on 7/30/1970 and that (in (X)) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce A. Mallin, M.D.			23B. DATE SIGNED 30 JULY 1970		
23C. PHYSICIAN'S NAME (Type) BRUCE MALLIN MD			23D. ADDRESS ST AGNES HOSPITAL BALTIMORE MD 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE AUG 3, 1970		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Amrose Inc. 1376 Sulphur Sp. Rd.			

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the limitations of the study, the strengths of the findings, and the potential for future research.

5. The fifth part of the report is a summary of the study. It includes a brief overview of the main findings and a final conclusion about the significance of the study.

6. The sixth part of the report is a list of references. It includes a list of all the sources used in the study, including books, articles, and other documents.

7. The seventh part of the report is an appendix. It includes any additional information that is relevant to the study, such as raw data, supplementary figures, or other documents.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. [REDACTED]	
W-410 70 7672		70 7672			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Wolf, Raymond Edward M.</i>		2. DATE AND HOUR OF DEATH <i>7-30-70 1:15pm</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Hartford View H.C.C.</i>			A. STATE <i>Maryland</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>1213 Light St. 21230.</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>M.</i> 6. RACE <i>W.</i>			E. STREET AND NUMBER <i>403 E. Clement St.</i>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-7-14</i>		9. AGE (In years last birthday) <i>55 yrs.</i>	
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
10A. KIND OF BUSINESS OR INDUSTRY <i>Sand Co.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Harry T. Wolf</i>			14. MOTHER'S MAIDEN NAME <i>Friederbaugh, Florence</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>No</i>			16. SOCIAL SECURITY NO. <i>214-01-2051</i>		
			17. INFORMANT ADDRESS <i>Mrs. Florence T. Wolf 403 E. Clement St.</i>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Cardiac Arrest</i>					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Artery Sclerosis</i>					
(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Gen'l Art Sclerosis</i>					
(C) <i>Paralysis Both legs</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>7/23</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/9</i> 19 <i>69</i> to <i>7/31</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>7/14</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Kenneth Krulovitz MD</i>				23B. DATE SIGNED <i>7/31/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>Kenneth Krulovitz MD</i>				23D. ADDRESS <i>115 W Monument St. Baltimore</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8 3 70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore</i>	
24D. LOCATION <i>Balto. Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>AUG 4 1970</i>		24F. NAME OF REGISTRAR <i>Robert E. Fisher, MD</i>	
24G. DATE REC'D BY HEALTH DEPT. <i>AUG 4 1970</i>		24H. NAME OF REGISTRAR <i>Robert E. Fisher, MD</i>		24I. FUNERAL DIRECTOR ADDRESS <i>Mc Cully 130 E. Fort Ave.</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

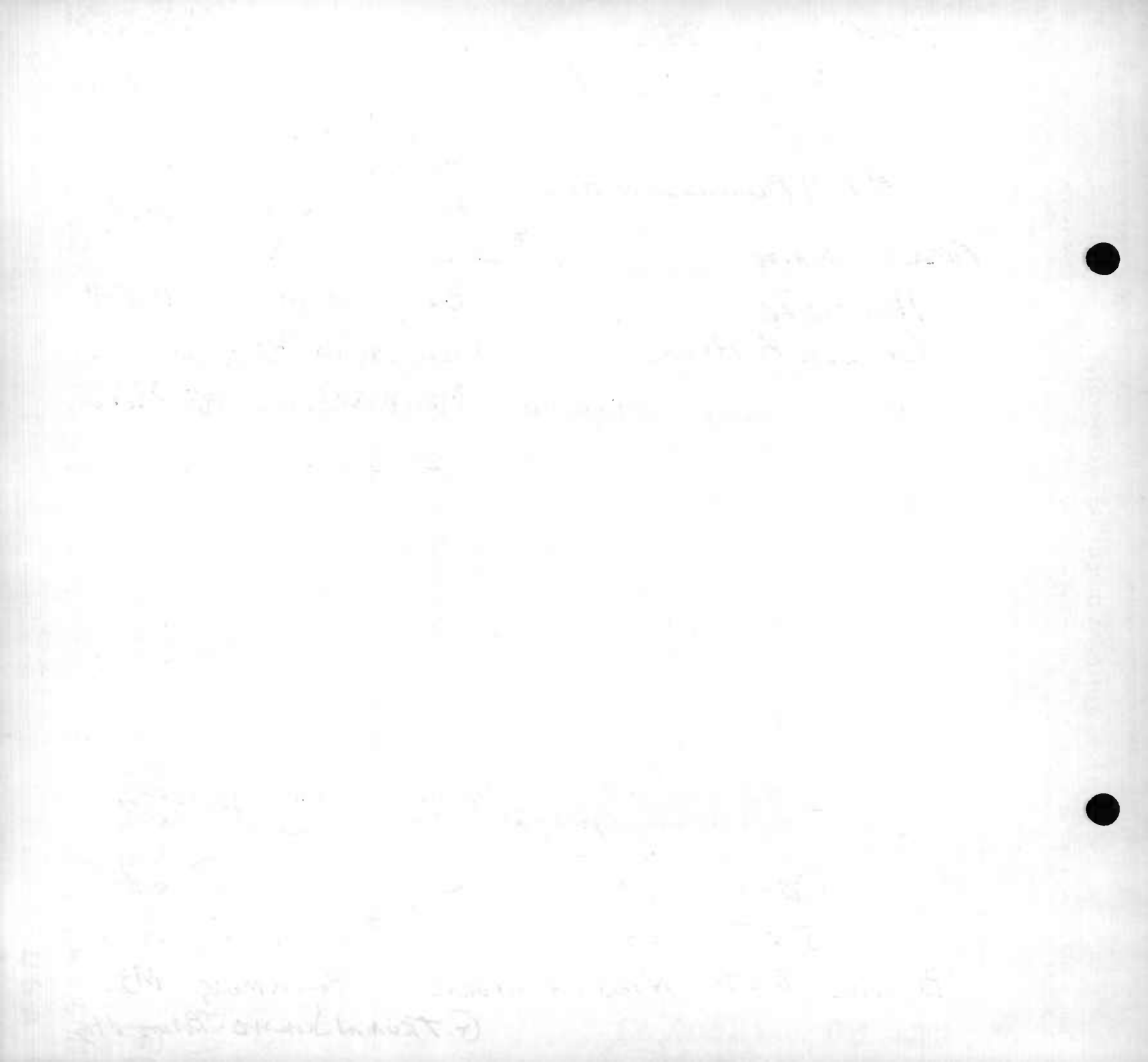
Baltimore City Health Department				REG. NO. 70 7673	
BIRTH NO. S-340		70 7673		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Ernest WILBUR STOLL			2. DATE AND HOUR OF DEATH 4-29-70 9:50 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME HOSPITAL			A. STATE MD. B. COUNTY BALTO.		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 9 W. FIFTH AVE. (25)					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/19/1885	9. AGE On years last birthday 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sub.		10B. KIND OF BUSINESS OR INDUSTRY sub.		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Charles Stoll		14. MOTHER'S MAIDEN NAME Emma Brulle	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service sub.		16. SOCIAL SECURITY NO.		17. INFORMANT Grace Stoll (Wife) ADDRESS 9 W. Fifth Ave. Balto, MD. (25)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 43671-185X CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular Accident (B) Generalized Atherosclerosis sub. (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days.			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A) Prostatic Carcinoma c metastasis 1 yr.		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (we) (this hospital) attended the deceased from July 29 1970 to July 29 1970 that (we) last saw the deceased alive on July 29 1970 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rolando Mendoza M.D.			23B. DATE SIGNED 7/29/70		23C. PHYSICIAN'S NAME (Type) ROLANDO MENDOZA M.D.
24A. BURIAL CREMATION, REMOVAL, (Specify) Burial			24B. DATE 8-1-70		24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery
24D. LOCATION Baltimore MD.			25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		
25B. NAME OF REGISTRAR Robert E. Talley M.D.			25C. FUNERAL DIRECTOR Wm. J. Tickner & Sons/William H. Fey		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

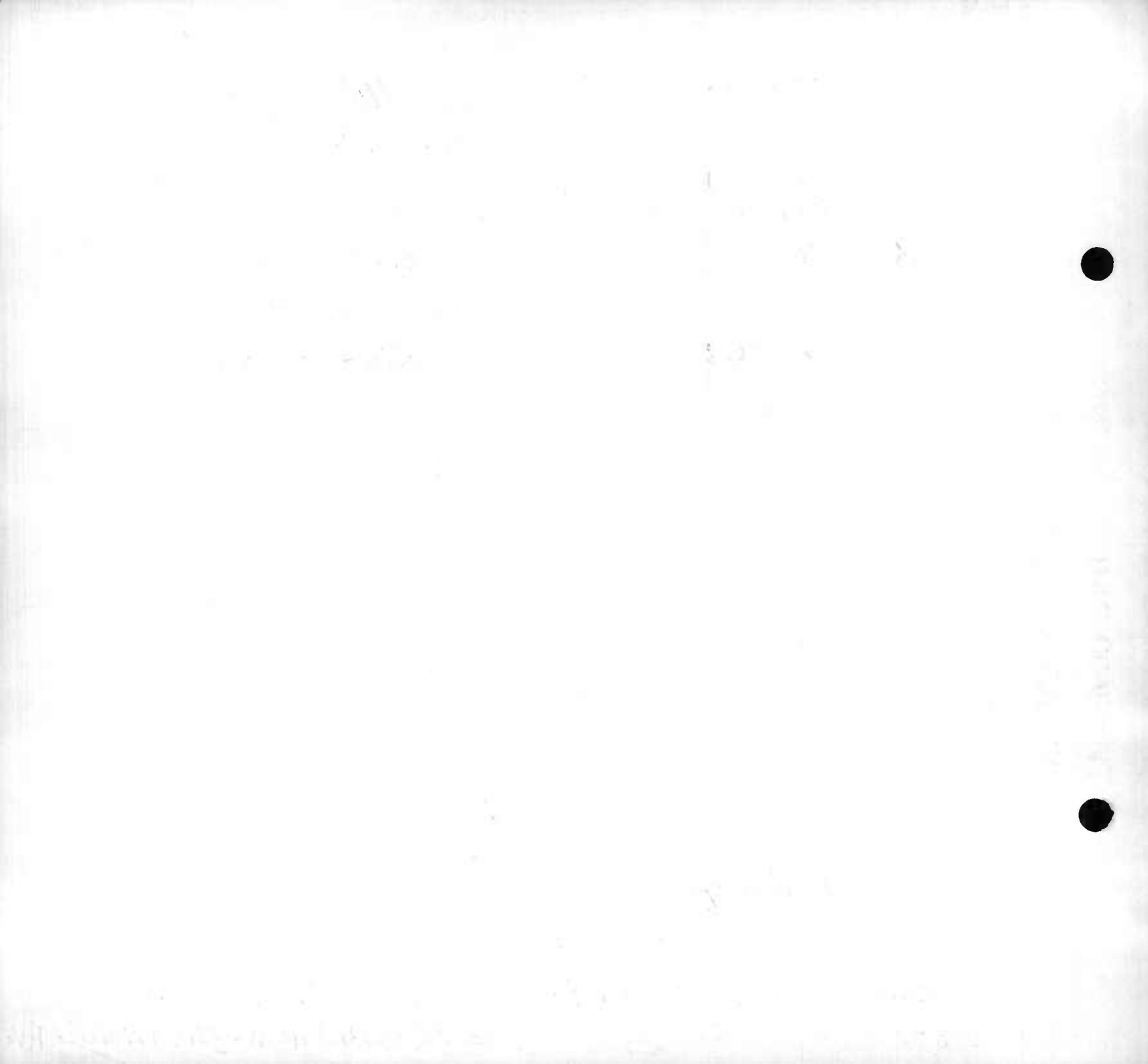
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7674	
H-200		70 7674		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ANNA M. HOCK		7.31.70 8:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 004909 EDMONDSON AVE				A. STATE MARYLAND	
				B. COUNTY 2834	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4904 EDMONDSON AVE	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3-28-82		88
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE				BALTIMORE MD.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
GEORGE A. HOCK			CHRISTINA BIRKMEYER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
<input checked="" type="checkbox"/>		UNKNOWN		Mrs. M. McGraw - 108 Paris Dr.	
18. 412.4 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				A. S. C. U. D year	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<input type="checkbox"/>					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1960 to July 31 1970 , that (I) (we) last saw the deceased alive on July 31 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
J. C. Pound				8/1/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
J. C. Pound		3325 Frederick Ave			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	8.3.70	New Cathedral		BALTIMORE MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 4 1970		Robert E. Taylor		G. Truman Schaub - Balt. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X	REG. NO. 70 7675
S-362 70 7675					
BIRTH NO. 65-30718					
1. NAME OF DECEASED (Type or Print) STRUCKO, BRIAN		2. DATE AND HOUR OF DEATH 8/1/70 4:20 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL BALTO, MD		A. STATE MAYLAND 5300 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 8117 Barksdale Rd #4			
5. SEX X	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/10/65	9. AGE (In years last birthday) 4	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE MD.	
13. FATHER'S NAME GEORGE		14. MOTHER'S MAIDEN NAME NINA-WRIGHT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 20791 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) LEUKEMIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE N. Radfar, M.D.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) NEZAM, RADFAR	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8.4.70		24C. NAME OF CEMETERY OR CREMATORY BELAIR MEMORIAL (GARDEN BELAIR MD)	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Rabey, R.D.		25C. FUNERAL DIRECTOR G. Truman Situms - 3512 FREDERICK AVE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. D-410		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 7676	
1. NAME OF DECEASED (Type or Print) Franklin C. Dold			2. DATE AND HOUR OF DEATH 7/30/70 9:15 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Cecil		
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital 4940 Eastern Avenue Baltimore, Md. 21224			C. CITY OR TOWN Rising Sun		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male			6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Antique dealer			10B. KIND OF BUSINESS OR INDUSTRY antique business		8. DATE OF BIRTH 8-15-08
13. FATHER'S NAME Phil Stevenson			14. MOTHER'S MAIDEN NAME Ethel		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 167-12-9009		9. AGE (in years last birthday) 61
11. BIRTHPLACE (State or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
17. INFORMANT BCH Records: Baltimore, Md. 21224			ADDRESS 4940 Eastern Avenue		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 41091			CAUSE OF DEATH (A) IMMEDIATE CAUSE CARDIAC ARREST 1 hr (B) DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL Infarction 3 (C) CARDIOGENIC SHOCK #2		
19. DATE OF OPERATION 0			20A. AUTOPSY? (Yes or No) NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 7/29/70 19 70 to 7/30/70 19 70 and that (I) (we) last saw the deceased alive on 7/30 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			23A. SIGNATURE Joel Chasis		
23B. DATE SIGNED 7/30/70			23C. PHYSICIAN'S NAME (Type) Joel Chasis, M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 8/2/70		
24C. NAME of CEMETERY or CREMATORY West Nottingham Cemetery			24D. LOCATION Cecil, Md.		
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970			25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		
25C. FUNERAL DIRECTOR RALPH M. REED			ADDRESS RISING SUN, MD		

V.S. 153

8-7-70

M.H.

70 7677

BALTIMORE CITY HEALTH DEPARTMENT

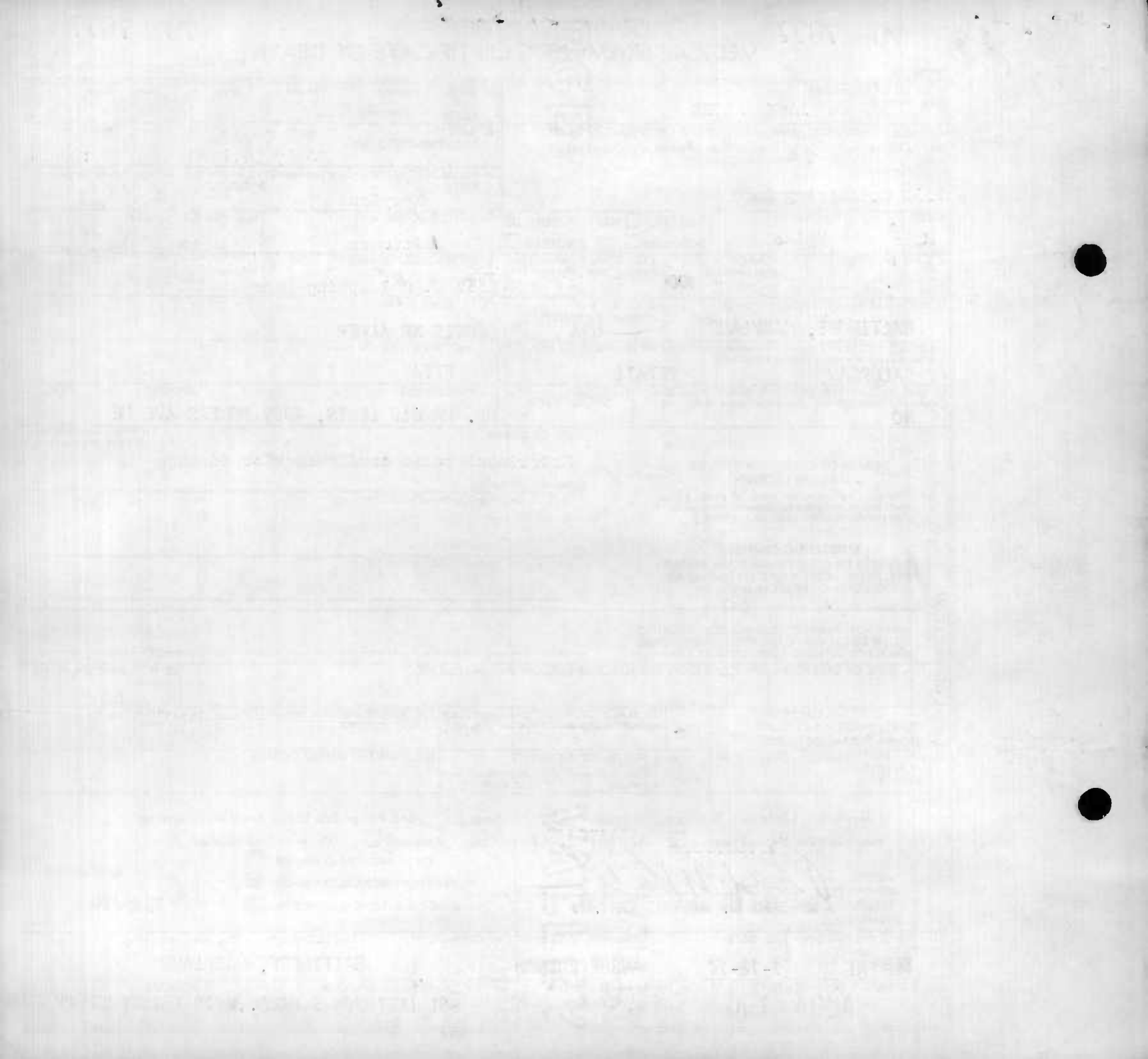
70 7677

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

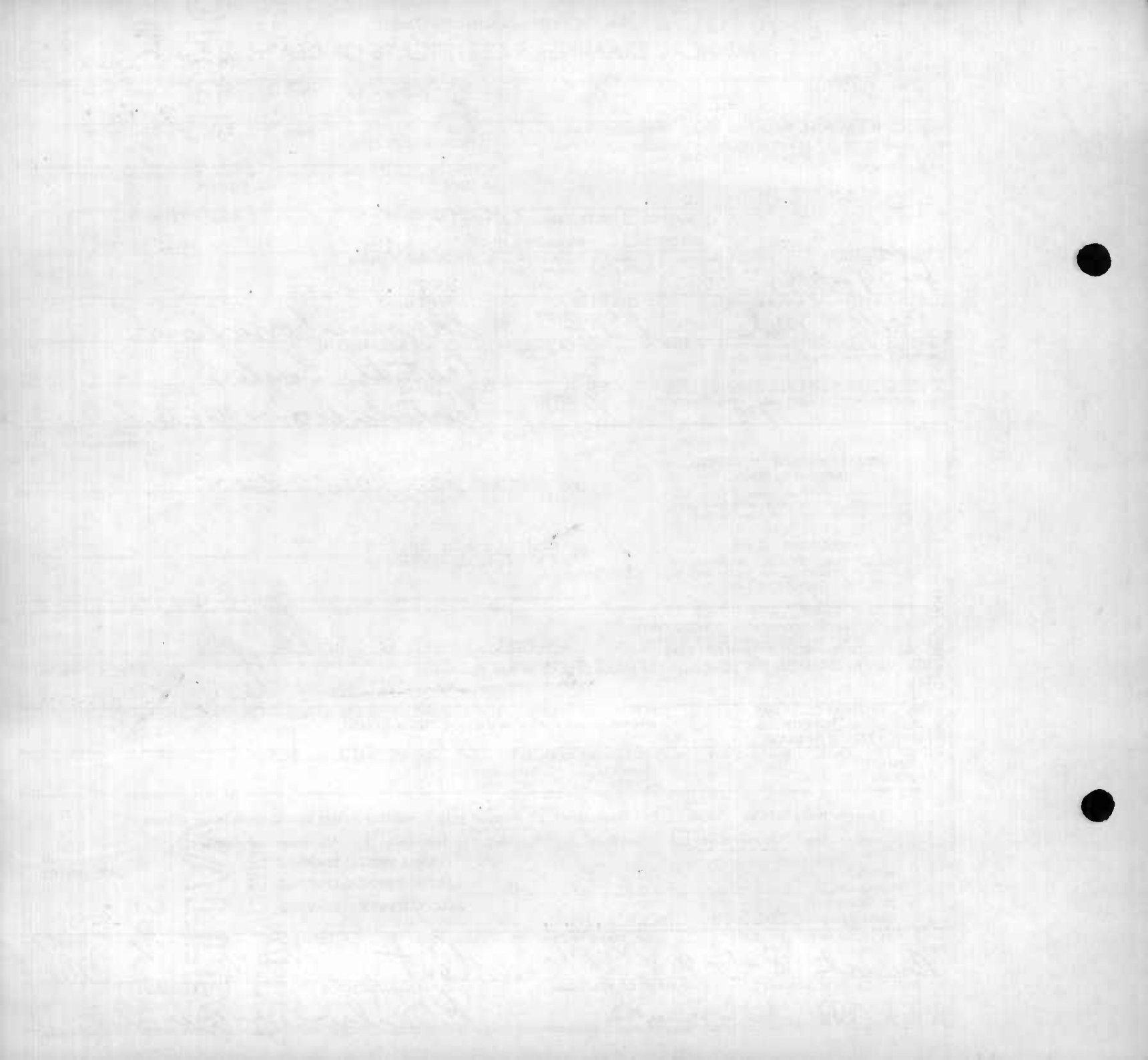
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JACK ALPER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2553 Coldspring Lane		3. DATE PRONOUNCED DEAD Month Day Year Hour July 14, 1970 10:20 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Sept. 6, 1900		10. AGE (In years last birthday) 69 XXX	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		15. MOTHER'S MAIDEN NAME ETTA ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	
18. INFORMANT MR. HAROLD LEWIS, 4009 BOWERS AVENUE		ADDRESS	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) NO	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/15/70			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-16-70	
24C. NAME OF CEMETERY or CREMATORY ANSHE EMUNAH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	



1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)	
C-524 70 7678 MAJOR CONIGLAND		Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/>		Month Day Year Hour 8- 1 1970 8:45A. M.		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
1007 E. Monument St.		Md.		501					
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 8-29-1939		10. AGE (In years last birthday) 31		11. BIRTHPLACE (State or foreign country) Balto Md		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Sherman Conigland	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Gertrude Laylor		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Gertrude Boone 712 E. Biddle St.		ADDRESS		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		Fatty liver with cirrhosis		DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(B) chronic alcoholism		DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES		(C)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		Tuberculosis (under therapy)							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		yes (Partial)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		8-30-70		Mt Vernon Cont		Balto Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
AUG 4 1970		Robert E. Farber, M.D.		E. Orlson		1001 B. Street			



H-620

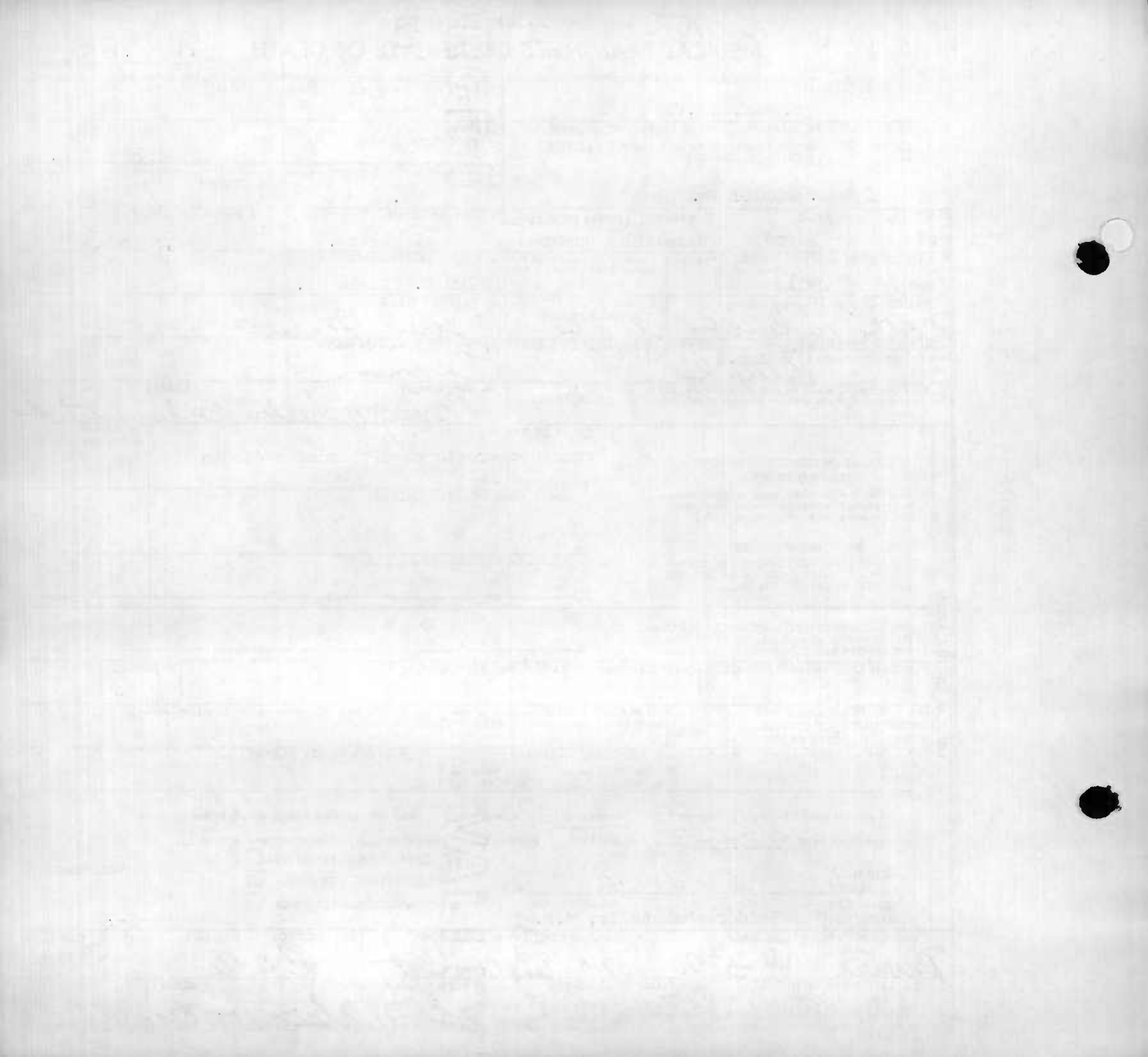
70 7679 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7679

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT HARRIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 700 E. Biddle St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 1 1970 11 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH April 16-1882		10. AGE (In years lost birthday) 89	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		15. MOTHER'S MAIDEN NAME Gennet P.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Nancy P. Fulton 720 August St		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) NO	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihaobakis, M.D. DATE SIGNED 8-2-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-5-70	
24C. NAME OF CEMETERY OR CREMATORY Int. Auburn Cent		24D. LOCATION (City, town, or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR E. Corbillion 1000 Brantley St		ADDRESS	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Ralph Stewart		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 31 70 12:55a	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home and Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 31 70 12:55a	
6. SEX male		7. RACE colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9-21-60		10. AGE (In years lost birthday) 39	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		13. FATHER'S NAME James Smiles	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give year or dates of service) No		15. MOTHER'S MAIDEN NAME Ella Warner	
17. SOCIAL SECURITY NO. 26-28-5317		18. INFORMANT Ella Warner	
19. CAUSE OF DEATH 304.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Narcotic overdose ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID IT IN BALTIMORE CITY, GIVE EXACT LOCATION) INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner		21. AUTOPSY? (Yes or No) yes DATE SIGNED 7/31/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-6-70	
24C. NAME OF CEMETERY OR CREMATORY Lenox		24D. LOCATION (City, town, or county) (State) North Carolina	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR Plenty Samuel Home		ADDRESS	

Letter from M.E.'s office

9-17-70

M.H.

ACADEMY

PAGE

1

A-536

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7681

BALTIMORE CITY HEALTH DEPARTMENT

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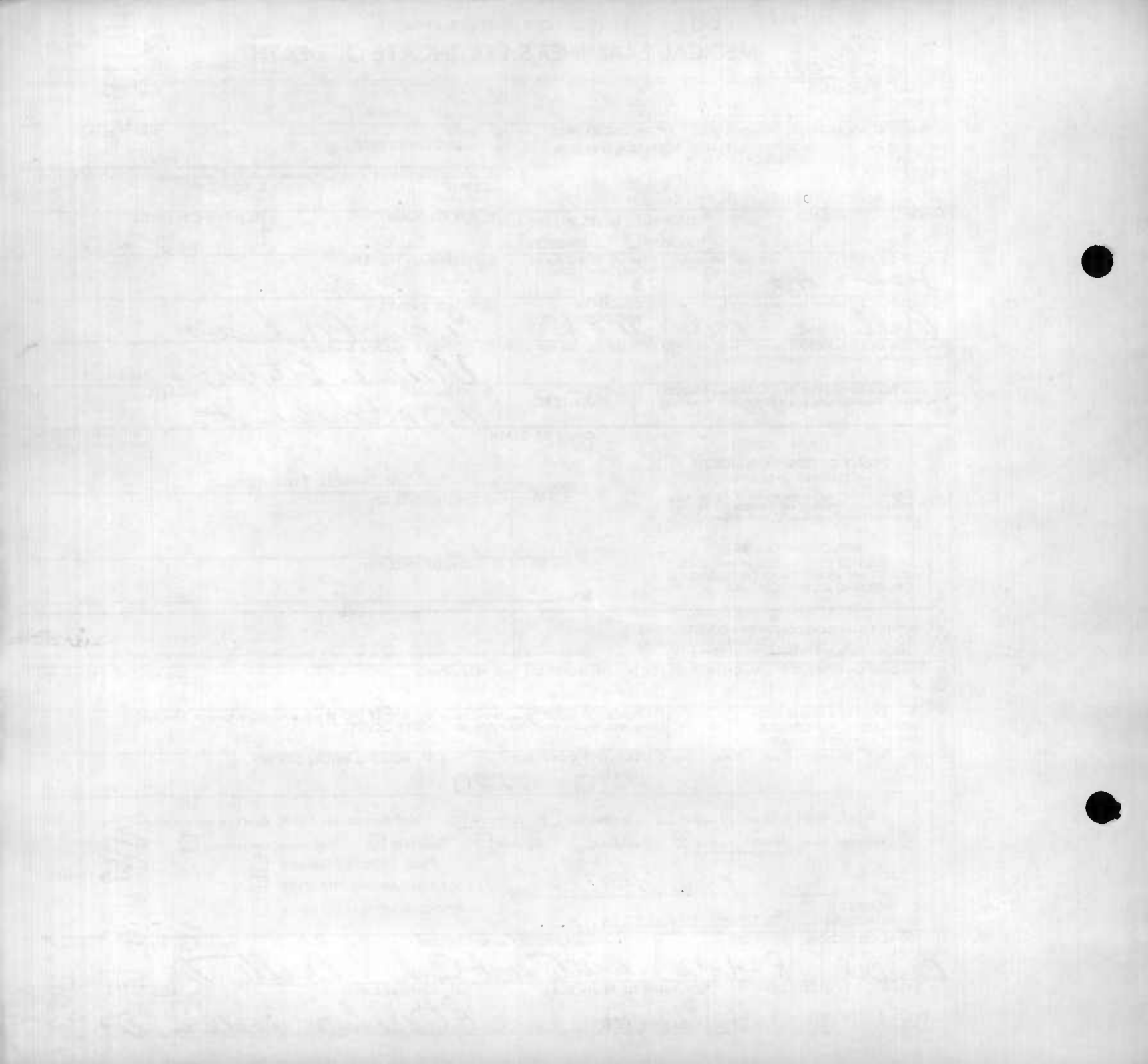
7681

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. 70-08889

1. NAME OF DECEASED (Type or Print) JONATHAN ANDERSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 1 1970 9:15 A.M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 808	
7. RACE Negro		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 1123 N. Caroline St.	
9. DATE OF BIRTH June 21 1970		10. AGE (in years last birthday) 23 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene Anderson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Marie Leticia Anderson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS 1123 N. Caroline St.	
19. 795X CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Sudden Death in Infancy (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-2-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-4-70	
24C. NAME OF CEMETERY or CREMATORY Balto Nat Cem		24D. LOCATION (City, town, or county) (State) Balto md	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Jenkins, M.D.	
25C. FUNERAL DIRECTOR E. Wilson		25D. ADDRESS 1000 Mount Airy	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY MADELINE CHAPPLE

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md.

2004

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

May 21, 1935

10. AGE (In years
last birthday)

35

11. Under 1 Yr. 11 Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2522 Hollins St.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Chapple

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Eleanor Scott

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Eleanor Scott 3501 Blakely Ave.

19. 57101

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE fatty liver
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Chronic alcoholism
DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes (PARTIAL)

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-2-70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-2-70

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 4 1970

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Evelyn Brown

ADDRESS

Page 10

Book 74

John Chapple

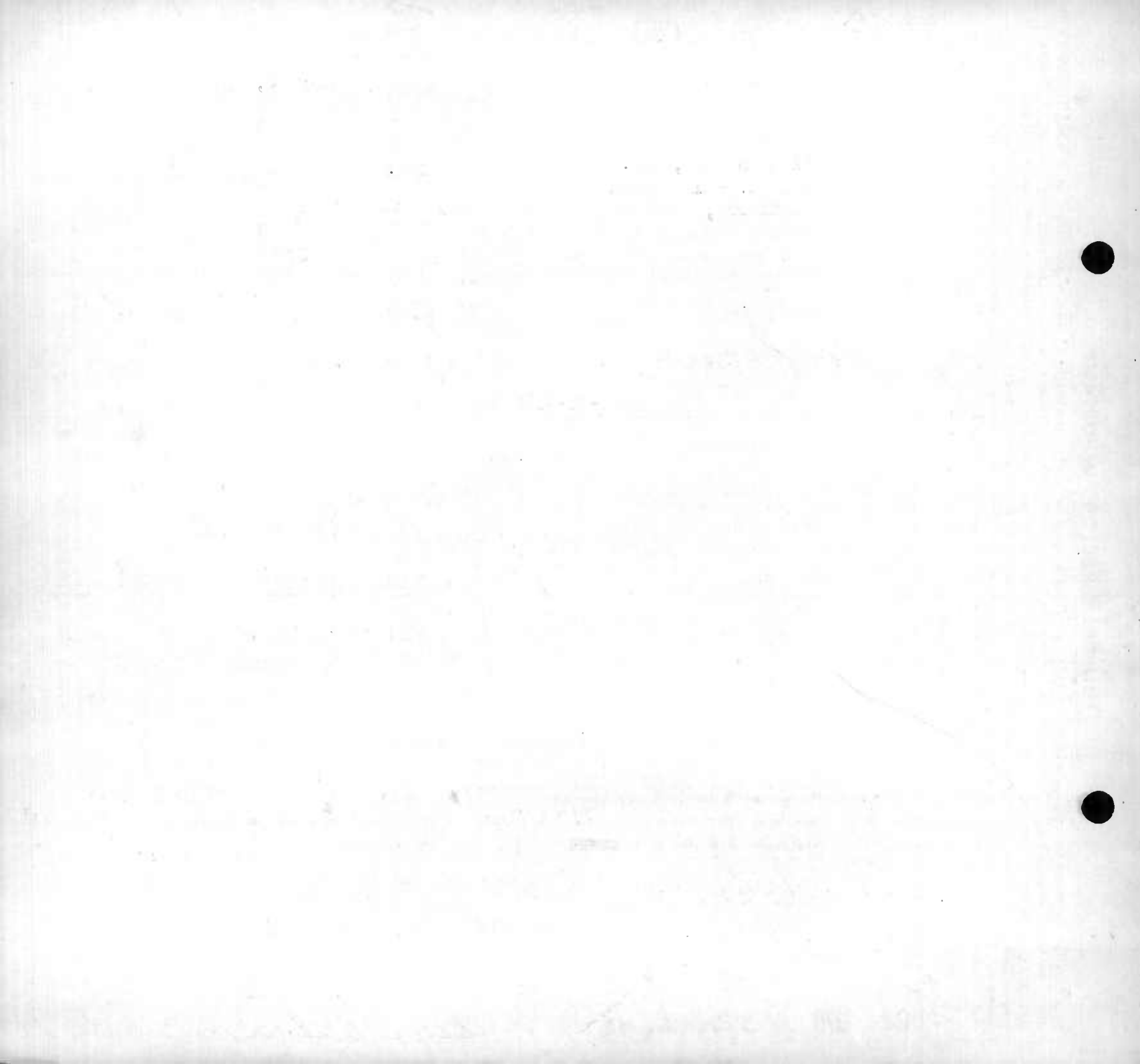
James West

2-27-70 1st Edition

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

Baltimore City Health Department				REG. NO. <u>70 7683</u>	
BIRTH NO. <u>H-400</u>		70 7683		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Mamie HILL</u>			2. DATE AND HOUR OF DEATH <u>July 26, 1970</u> <u>1005</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Midtown Home, Inc.</u> <u>808 St. Paul Street</u> <u>Baltimore, Md 21202</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>1302</u>		
5. SEX <u>F</u>		6. RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. AGE (In years last birthday) <u>67</u>		9. AGE (In years last birthday) <u>67</u>		10. AGE (In years last birthday) <u>67</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>217-05-8516</u>		17. INFORMANT <u>Paul Hill</u>
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardio Respiratory Failure</u> <u>Ant. C.V.N.D.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Ascending Pyelonephritis</u> <u>Sporadic Paraplegia (stroke)</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/21/70</u> 19 to <u>7/26/70</u> 19, that (I) (we) last saw the deceased alive on <u>7/26/70</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <u>William Appleford</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>William Appleford</u>				23D. ADDRESS <u>6615 Keisterman Rd</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-29-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Nottingham</u>	
24D. LOCATION (City, town, or county) <u>Balto</u>		24E. (State) <u>Md</u>		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Eloy Wilson</u>	
25D. ADDRESS <u>1001 Beantley Rd</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-360 70 7684		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 7684	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) HERMIE GAITHER		2. DATE AND HOUR OF DEATH 7-26-70 12:03 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1513		C. CITY OR TOWN BALTO.	
FULL NAME OF HOSPITAL OR INSTITUTION 4 SINAI HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 8-22-04	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday) 65	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) Maryland U.S.A.	
17. INFORMANT		ADDRESS		12. CITIZEN OF WHAT COUNTRY	
18. 4-10-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH PROBABLE MYOCARDIAL INFARCTION		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ATHEROSCLEROTIC CARDIOVASCULAR DISEASE			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). LOBAR PNEUMONIA					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-23 19 70 to 7-26 19 70 that (I) (we) last saw the deceased alive on 7-26 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Arthur M. Wagner, M.D.				23B. DATE SIGNED 7-26-70	
23C. PHYSICIAN'S NAME (Type) ARTHUR M. WAGNER				23D. ADDRESS SINAI HOSPITAL OF BALTO.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-30-70		24C. NAME of CEMETERY or CREMATORY Interden Cemetery	
24D. LOCATION (City, town, or county) (State) A.C. County Md		25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Ed Wilson		ADDRESS 100 Broadway St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-452		70 7685		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7685	
1. NAME OF DECEASED (Type in Print) BLANKS, ORA				2. DATE AND HOUR OF DEATH 7-25-70 8:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSP. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 830 George ST.			
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-12-1904		9. AGE (In years, lost birth) 66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jerry Blackwell				14. MOTHER'S MAIDEN NAME Elena Washington			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wd or dates of service) No		16. SOCIAL SECURITY NO. 212-30-8330		17. INFORMANT Mattie Blackwell		ADDRESS 2113 S. Smallwood St	
18. 15-4-0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SHOCK ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ① RUPTURED DIVERTICULITIS ② RECTOSIGMOID CARCINOMA (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from JULY 24, 1970 to JULY 25, 1970 , that the (we) last saw the deceased alive on JULY 25, 1970 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. the (We) (did) (not) view the body after death.							
23A. SIGNATURE Christos Dibranos, M.D. DEGREE				23B. DATE SIGNED JULY 25, 70		23C. PHYSICIAN'S NAME (Type) CHRISTOS DIBRANOS, M.D. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7-30-70		24C. NAME OF CEMETERY or CREMATORY Bald Nat Cent	
24D. LOCATION BALTO MD MD				24E. NAME OF REGISTRAR Robert E. Farber, M.D.		24F. FUNERAL DIRECTOR E. Wilson	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970				25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR E. Wilson	

1944

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 7686	
BIRTH NO. B-550		70 7686		DATE AND HOUR OF DEATH 8/2/70 17:50	
1. NAME OF DECEASED (Type or Print) Bowman, Blease			2. DATE AND HOUR OF DEATH 8/2/70 17:50		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) Johns Hopkins Hospital 601 Broadway Balto. Md 21205			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY Balto. County		
5. SEX M			6. RACE N		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 07-15-12		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Baltimore, Md			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Chestnut			14. MOTHER'S MAIDEN NAME Maybelle Bowman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 228-05-0700		
17. INFORMANT Old records			ADDRESS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Anemia 20 acute bleed DUE TO, OR AS A CONSEQUENCE OF: (C) Chronic obstructive Lung Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Possible Neurosyphilitic & Aortic Aortitis					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 7-14 19 70 to August 2 19 70 that (2) (we) lost saw the deceased alive on August 2 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Peter Densen MD				23B. DATE SIGNED August 2, 1970	
23C. PHYSICIAN'S NAME (Type) Peter Densen MD				23D. ADDRESS 601 N. Broadway Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8-8-70		Caret	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Farley MD		25C. FUNERAL DIRECTOR E. Wilson	
25D. LOCATION (City, town, or county)		25E. ADDRESS			
Lumal		mel			

9/4/70 - Correction from General Director.
Be.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
70 7687 CERTIFICATE OF DEATH					REG. NO. 70 7687				
1. NAME OF DECEASED (Type or Print) Cornell Outlaw					2. DATE AND HOUR OF DEATH July 31, 1970, 10:43 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital (Osler-3) 33601 Broadway Baltimore, Md 21205					A. STATE Md. B. COUNTY Baltimore				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN Baltimore City D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
					E. STREET AND NUMBER 1533 N. Wolfe St.				
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-8-93	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel worker				10B. KIND OF BUSINESS OR INDUSTRY Sparrows Point		11. BIRTHPLACE (State or foreign country) Baltimore, Md			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Alexander				14. MOTHER'S MAIDEN NAME Harriet - ??					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. 216-09-5424		17. INFORMANT old Chart			ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 5-19-21				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Probable Heart Attack				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic obstructive lung Disease				(B) DUE TO, OR AS A CONSEQUENCE OF: 2 Severe Arteriosclerosis				years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from July 31 19 70 to July 31 19 70 that (I) (we) lost saw the deceased alive on July 31 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Peter Densen MD					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED July 31, 1970	
23C. PHYSICIAN'S NAME (Type) Peter Densen MD					23D. ADDRESS 601 N. Broadway, Baltimore Md				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial Removal		24B. DATE 8-5-70		24C. NAME OF CEMETERY OR CREMATORY Walt Whitman		24D. LOCATION (City, town, or county) (State) Balto Md			
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Corlison 1000 Chantilly R					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 7688

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARIA HARRIS

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
OR INSTITUTION ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

8

1

1970

1:35 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Md.

B. COUNTY

806

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

July 4, 1913

10. AGE (In years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1624 Lansing Ave.

11. BIRTHPLACE (State or foreign country)

Penn.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Josh Long

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Carpenter

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mathie Morris

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

Harold Long 332 Boulder Lane Orange, Va.

ADDRESS

19.

4-12-70

CAUSE OF DEATH

Hypertensive & arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-2-70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/5/70

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem.

24D. LOCATION

(City, town, or county)

(State)

G. C. County Md

25A. DATE REC'D BY HEALTH DEPT.

AUG 4 1970

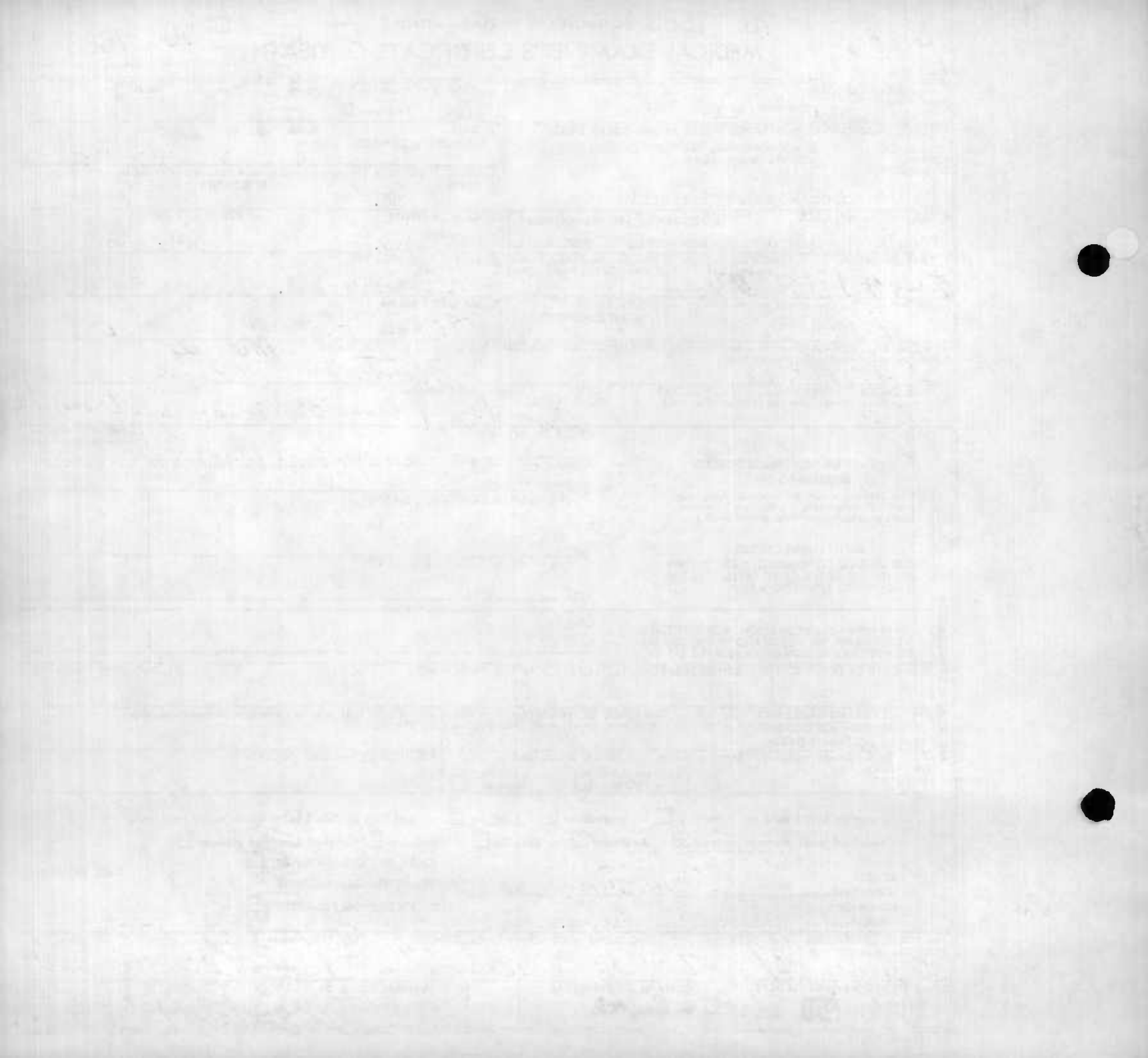
25B. NAME OF REGISTRAR

Robert E. Fahey, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Joseph B. Rocke, Jr. 1304 R. Central Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

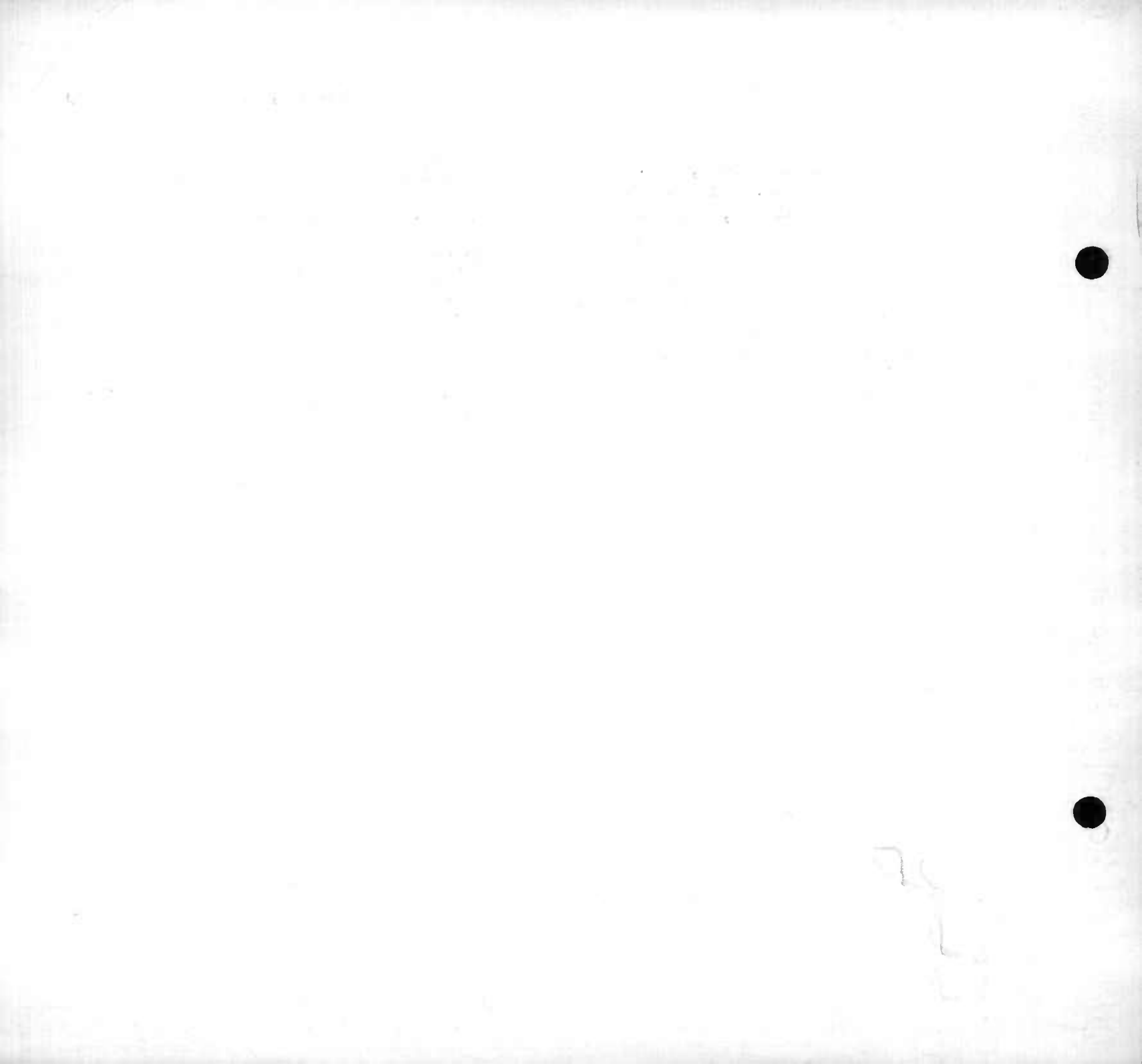
C-650 70 7689		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 7689	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>CORUM, Nettie</u>		2. DATE AND HOUR OF DEATH <u>8-2-70</u> <u>3:00</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1001</u>		C. CITY OR TOWN <u>BALTIMORE</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>1138 HARFORD AVE</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/1/92</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. <u>Daquinez Co. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Brooks</u>		14. MOTHER'S MARDEN NAME <u>Nettie Brooks</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>229-26-1690</u>		17. INFORMANT <u>Flarence Richardson Calverton, Va.</u>	
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osiemia, etc. It means the disease, injury or complication which caused death.) <u>Ventricular tachycardia due to myocardial infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(B) due to coronary artery disease</u>		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7-20</u> 19 <u>70</u> to <u>8-2</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>8-2</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Larry Kvols, M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8-2-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>LARRY KVOLS</u>		23D. ADDRESS <u>Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <u>CALVERTON, Md.</u>	
24D. LOCATION (City, town, or county) (State) <u>MIDLAND, VA</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Joseph B. Locks Jr</u>		ADDRESS <u>1304 N. Central Ave</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 7690
70 7690 CERTIFICATE OF DEATH			REG. NO. 70 7690	
1. NAME OF DECEASED (Type or Print) James Johnson			2. DATE AND HOUR OF DEATH August 1, 1970 4:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202			A. STATE Md B. COUNTY 501	
			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
			E. STREET AND NUMBER 322 N. Exeter Street	
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/10/11	9. AGE (in years last birthday) 58
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10B. KIND OF BUSINESS OR INDUSTRY PRINTING	
11. BIRTHPLACE (State or foreign country) N.C.			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Johnson			14. MOTHER'S MAIDEN NAME MARIA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.	
			17. INFORMANT Lottie Johnson 1516 May CT	
			ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Lung			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on 7/19 19 70 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Stephen Miller MD			23B. DATE SIGNED 8/3/70	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS	
DEGREE				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8/5/70		24C. NAME OF CEMETERY or CREMATORY Mt. Carmel
24D. LOCATION (City, town, or county) (State) G. B. County, Md				
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Miller, R.A.		25C. FUNERAL DIRECTOR Joseph J. Locks
				ADDRESS 1304 R. Connel Ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7691	
<div> <div>4-300</div> <div>70 7691</div> <div>CERTIFICATE OF DEATH</div> </div>					
BIRTH NO. (NANNIE CHAPMAN REED) 1. NAME OF DECEASED (Type or Print) REED NANCY			2. DATE AND HOUR OF DEATH 8-2-70 12.05 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HCL & T. TOTAL			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 203 W. PAUL STREET		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07-28-92	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED C.M.V.			11. BIRTHPLACE (State or foreign country) Baltimore Md		
10B. KIND OF BUSINESS OR INDUSTRY RETIRED C.M.V.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Wm. Reed			14. MOTHER'S MAIDEN NAME NELLIE C. BOYLE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. HELLER 0000		
17. INFORMANT Mrs. George J. Phillips (Cousin)			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 584X1			CAUSE OF DEATH A Carrollton Apts.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Renal failure					
(B) Chronic Pyelonephritis DUE TO, OR AS A CONSEQUENCE OF:					
(C) Atrophic Kidney					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month () Day () Year () Hour ()		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-25-70 to 8-2-70 that (I) (we) last saw the deceased alive on 8-1-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. P. Mikos M.D.				23B. DATE SIGNED 8/2-70	
23C. PHYSICIAN'S NAME (Type) J. P. MIKOS				23D. ADDRESS UMH	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 5. 1970		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970			
25B. NAME OF REGISTRAR Robert E. Sander, Jr.		25C. FUNERAL DIRECTOR HENRY SANDER & SONS, INC.			
25D. ADDRESS Baltimore Md.		ADDRESS			

C — X

VMC

Wm. Green

R. S. S.

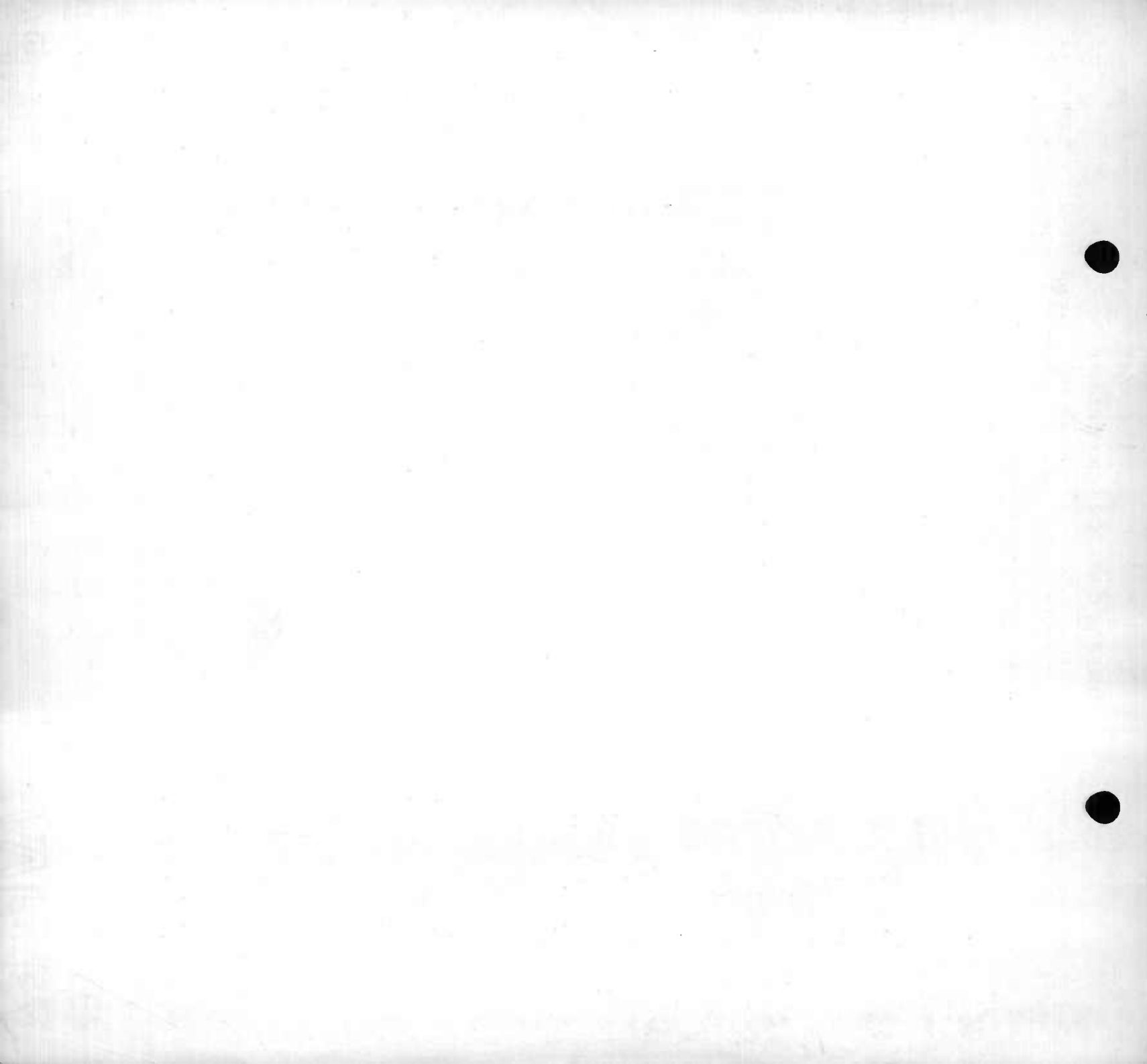
Brace, M.

W.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 707 70 7692	
BIRTH NO. 70 7692		1. NAME OF DECEASED (Type or Print) ROBERTSON, MARY		2. DATE AND HOUR OF DEATH 7/2/70 6:45 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY 1302			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HARBOR VIEW NURSING & CONVA. CENTER		C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 5/10/16 9. AGE (In years last birthday) 60	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER 2209 EUTAW PLACE	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 15-7-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Carcinoma pancreas		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-5-1970 to 7-2-1970, that (I) (we) last saw the deceased alive on 7-2-1970 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Ellsworth Cook M.D.		23B. DATE SIGNED 7-3-70		23C. PHYSICIAN'S NAME (Type) E. Ellsworth Cook M.D.	
23D. ADDRESS 2431 Md. Ave. Balto. Md. 21218		24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 7/22/70	
24C. NAME of CEMETERY or CREMATORY Corner Memorial Park		24D. LOCATION (City, town, or county) Maryland		24E. STATE	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Md.		25C. FUNERAL DIRECTOR 1. G. G. G. F. 11	



F 536

70 7693

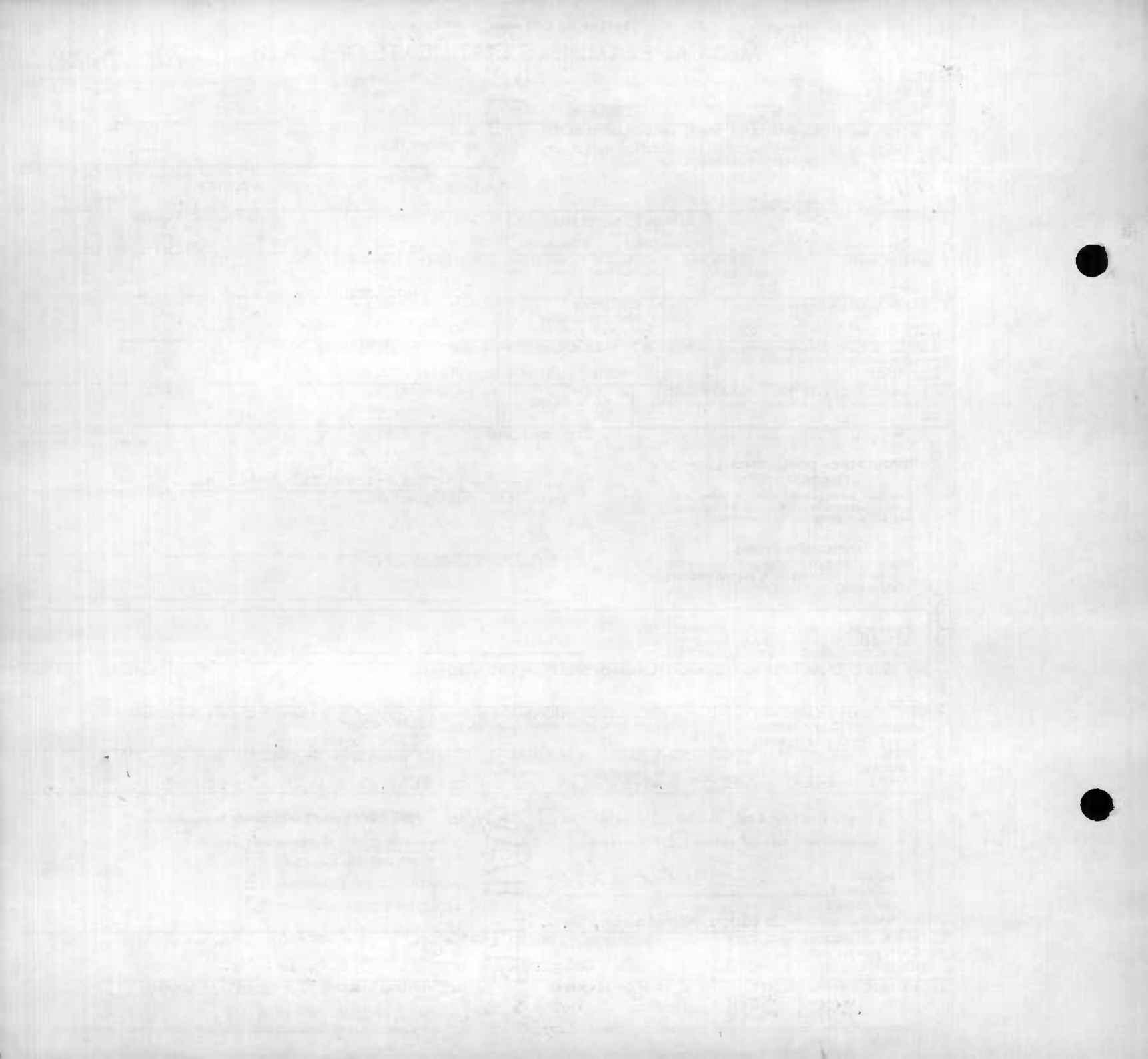
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7693

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM FUNDERBURK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 City Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 1 1970 11:45 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY AA C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		5200	
6. SEX Male	7. RACE Negro	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 7-24-30	10. AGE (In years lost birthday) 40	E. STREET AND NUMBER 754 Woodlawn Ave.	
11. BIRTHPLACE (State or foreign country) Chester, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		15. MOTHER'S MAIDEN NAME Annie Davis	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs. Lucille Funderburk		ADDRESS 754 Woodlawn Av.	
19. E 9681 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cranio-cerebral injuries DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house	
22D. TIME OF INJURY (APPROX.) 8-1-70 12:20 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Subj. hit on head with blunt object.		21. AUTOPSY? (Yes or No) yes (head only)	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-2-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-5-70	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) A.A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Sabe, M.D.	
25C. FUNERAL DIRECTOR Marshall W. Jones, Jr.		25D. ADDRESS 735 Harford Ave. 21213	

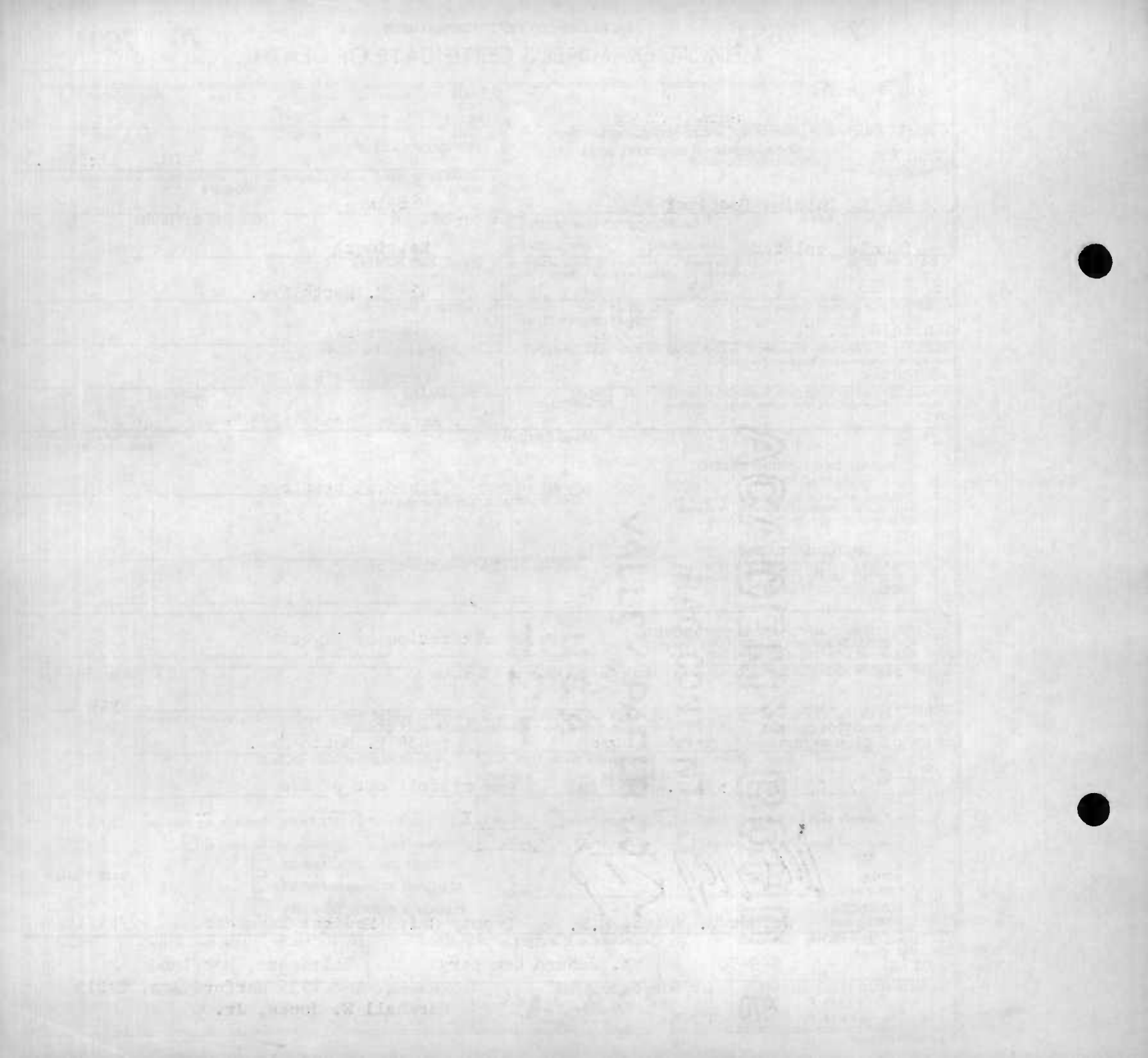


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		L.		2. DATE OF DEATH		Known <input checked="" type="checkbox"/> Month Day Year		Estimated <input type="checkbox"/> M.	
Sarah Jones				3. DATE PRONOUNCED DEAD		Month Day Year		Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		7 30 70		11:50 p.m.	
33 Hopkins Hospital				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE		B. COUNTY	
				Maryland		1204			
6. SEX	7. RACE	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
female	colored	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH	10. AGE (In years lost birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER					
3 4 33	37			434 E. North Ave.					
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME					
Enfield, N. C.		U.S.A.		Joe Vinson					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME					
Domestic				Bessie Gerald					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS			
no				Mrs. Martha Townes		1785 Montpelier St. 18			
19. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		Subdural hematoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B)		DUE TO, OR AS A CONSEQUENCE OF:			
				(C)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Fatty alteration of liver							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		434 E. North Ave.		1204	
22D. TIME (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?					
7 25 70 9:00 a.m.		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		fell out of bed					
23. I certify that, held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER		DATE SIGNED			
ACTUAL SIGNATURE		M.D.		ASSISTANT MEDICAL EXAMINER					
EXAMINER'S NAME (Type)		Werner U. Spitz, M.D.		ASSOCIATE MEDICAL EXAMINER					
		Deputy Chief Medical Examiner		7/31/70					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		8-3-70		Mt. Auburn Cemetery		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		1735 Harford Ave. 21213			
AUG 4 1970		Robert E. Jaber, M.D.		Marshall W. Jones, Jr.					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMIE M. DAUGHTEREY

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

July 29, 1970

4:15 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(If not in hospital or institution, give street
address or location)

39 Provident Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

July 29, 1970

4:15 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

833

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

3-7-70

10. AGE (In years
last birthday)11. Under 1 Yr. 12. Under 24 Hrs.
Months Days Hours Min.

4

E. STREET AND NUMBER

2612 E. Oliver Street

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alvin Daughtrey

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

INFANT

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Rita J. Chambers

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

None

18. INFORMANT

ADDRESS

Junior Chambers 2612 E. Oliver St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Apparent electrolyte imbalance

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Vomiting and diarrhea

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 30, 1970

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-3-70

24C. NAME of CEMETERY or CREMATORY

Arbutus Memorial PK

24D. LOCATION (City, town, or county)

Arbutus,

Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 4 1970

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Randolph J. Collick 2431 E. Oliver St.

ADDRESS

R. 520

70 7696

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7696

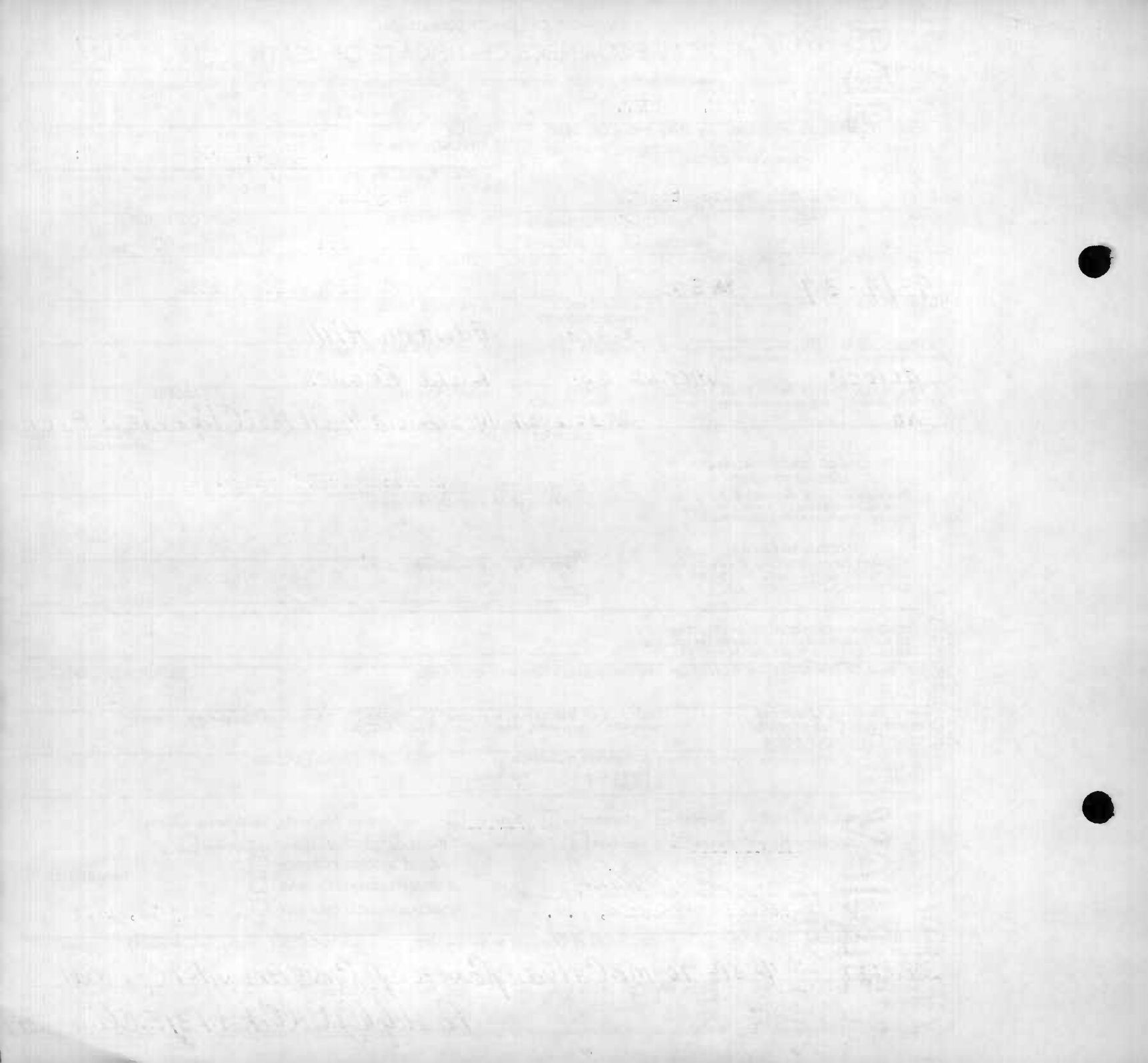
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Boyd Ramsey		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 30 70 1:30 p.m.		5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 2739	
6. SEX male	7. RACE colored	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 6-30-14		10. AGE (In years lost birthday) 56		E. STREET AND NUMBER 1310 Silverthorne Rd.	
11. BIRTHPLACE (State or foreign country) Roxboro, N.C.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Sam Ramsey	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		14B. KIND OF BUSINESS OR INDUSTRY Steamship Co		15. MOTHER'S MAIDEN NAME Lucy Thomas	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217-14-0200		18. INFORMANT Mrs Daisy Ramsey ADDRESS 1310 Silverthorne Rd.	
19. CAUSE OF DEATH 412.4		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTECEDENT CAUSES		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner DATE SIGNED 7/31/70 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 8-2-70		24C. NAME OF CEMETERY OR CREMATORY Lawson Chapel Cemetery Roxboro, N.C.	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Tauber, M.D.		25C. FUNERAL DIRECTOR Randolph J. Collick ADDRESS 2431 E. Oliver St.	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) MANUEL HILL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 806 North Wolfe Street		3. DATE PRONOUNCED DEAD Month Day Year Hour July 27, 1970 12:46 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 704	
9. DATE OF BIRTH 9-19-37		10. AGE (In years lost birthday) 32	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Hill		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper	
15. MOTHER'S MAIDEN NAME Lula Pegues		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, near unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 24-32-6904		18. INFORMANT Mrs. Lula Mull 1660 Clifview Ave.	
19. CAUSE OF DEATH 7319		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)	
20A. DATE OF OPERATION 7-31-70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 28, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-31-70	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Randolph J. Collick		ADDRESS 2431 E. Oliver St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 7698				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7698			
1. NAME OF DECEASED (Type or Print) HERBERT HALEY or Haley				2. DATE AND HOUR OF DEATH 7-30-70 1:35 P.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 906							
FULL NAME OF HOSPITAL OR INSTITUTION MT. SINAI NURSING HOME				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4613 PARK HEIGHTS AVE.				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX MALE 6. RACE BLACK				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 12-18-04 9. AGE (In years last birthday) 65			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BURNER				10B. KIND OF BUSINESS OR INDUSTRY Steel Co.				11. BIRTHPLACE (State or foreign country) Warrington, Va.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME George Haley				14. MOTHER'S MAIDEN NAME Nannie Tackett			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 21307-2446				17. INFORMANT Mrs Geneva Haley ADDRESS 1706 E. 29th St.			
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio- (A) IMMEDIATE CAUSE Due to, or as a consequence of: Vascular Disease Hypertension (B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral Vascular Accident (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 28 19 70 to July 30 19 70 , that (I) (we) last saw the deceased alive on July 30 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Louis T. Lavy M.D. DEGREE				23B. DATE SIGNED Aug 3 1970							
23C. PHYSICIAN'S NAME (Type) LOUIS T. LAVY M.D. DEGREE				23D. ADDRESS 3502 W. Lovers Ave Baltimore Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) Removal				24B. DATE 8-2-70				24C. NAME OF CEMETERY OR CREMATORY St. James Cemetery			
24D. LOCATION (City, town, or county) Beaumont, Va.				24E. (State) VA.							
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970				25B. NAME OF REGISTRAR Randolph J. Collick				25C. FUNERAL DIRECTOR ADDRESS 2431 E. Oliver St.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 70 7699

BIRTH NO. 70 7699

1. NAME OF DECEASED
(Type or Print)

Harry Brannoch Collison

2. DATE AND HOUR OF DEATH
Aug. 2, 1970

7:32 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 Ambassadors Apartments

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

Ambassadors Apartments

5. SEX

M

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

2-19-1886

9. AGE (In years last birthday)

84

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

Central

10B. KIND OF BUSINESS OR INDUSTRY

Savings Bank

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Henry Collison

14. MOTHER'S MAIDEN NAME

?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.
213-10-1895

17. INFORMANT

ADDRESS

Mrs. George C. Bayley Montrose Ave.

18. 10.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

several hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) Arteriosclerotic cardiovascular dis.
DUE TO, OR AS A CONSEQUENCE OF:

(C) Myocardial ischemia and hypertension

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (did not) attended the deceased from August 1 19 70 to August 1 19 70 that (I) (we) last saw the deceased alive on August 1 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. J. Sheldon Eastland

Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

8/3/70

23C. PHYSICIAN'S NAME (Type)

Dr. J. Sheldon Eastland

23D. ADDRESS

Medical Arts Building

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-4-1970

24C. NAME of CEMETERY or CREMATORY

Druid Ridge Cemetery

24D. LOCATION

(City, town, or county)

(State)

Pikesville, Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 4 1970

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

H. V. Jenkins & Sons Co.

ADDRESS

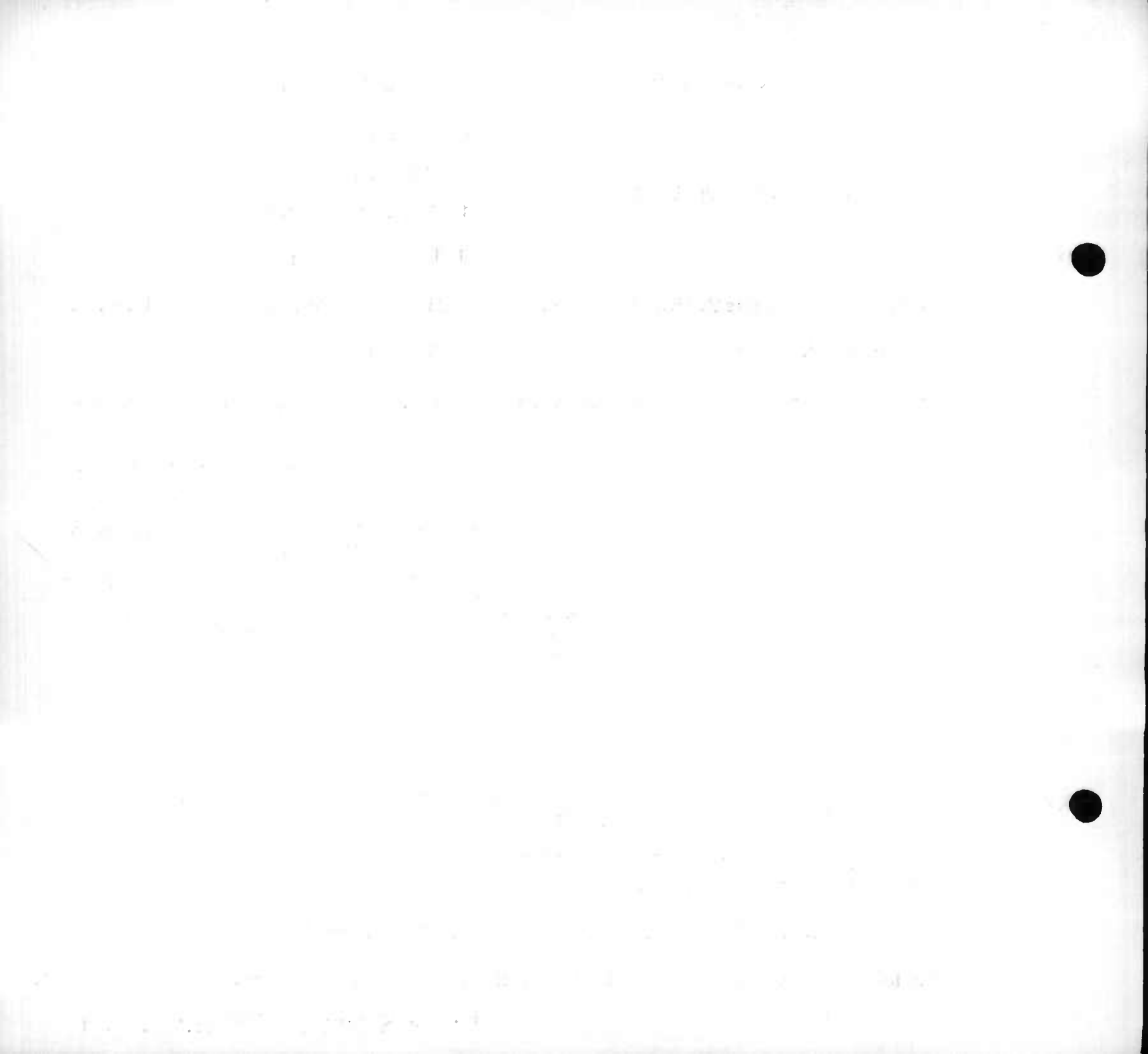
4905 York Road Balto., Md. 21212

4E

3811 Canterbury Rd.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

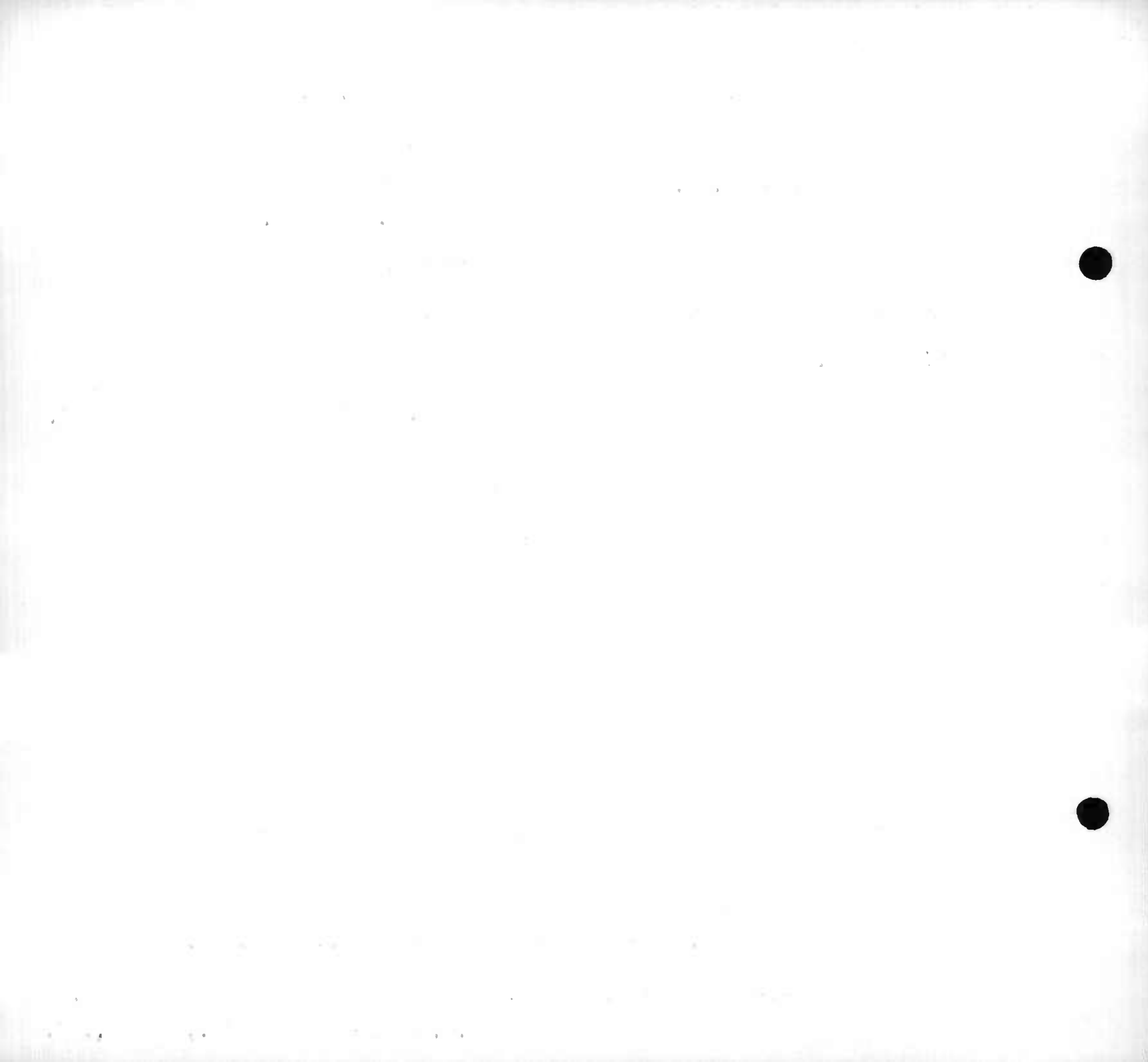
BALTIMORE CITY HEALTH DEPARTMENT				70 7700	
CERTIFICATE OF DEATH				REG. NO. 70 7700	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		John Kratz		July 31, 1970 9:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institutions; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE 8. COUNTY	
90 Edgewood Nursing Home				Maryland	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				1627 E. 33rd Street	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3-1-1889		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			9. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)
Freight Claim Investigator B&O RR.			81		Baltimore, Maryland
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Frank P. Kratz			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
Yes WWI			705-09-1551		Mrs. Fannie C. Kratz Same
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10/4/65 to 7/31 1970 that (I) (we) last saw the deceased alive on 7/31 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. William F. Renner				8/4/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. William F. Renner				3222 St. Paul Street	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		8-4-70		Baltimore National Cemetery Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 4 1970		Robert E. Taylor, M.D.		H. W. Jenkins & Sons Co. 4905 York Road Balto. Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

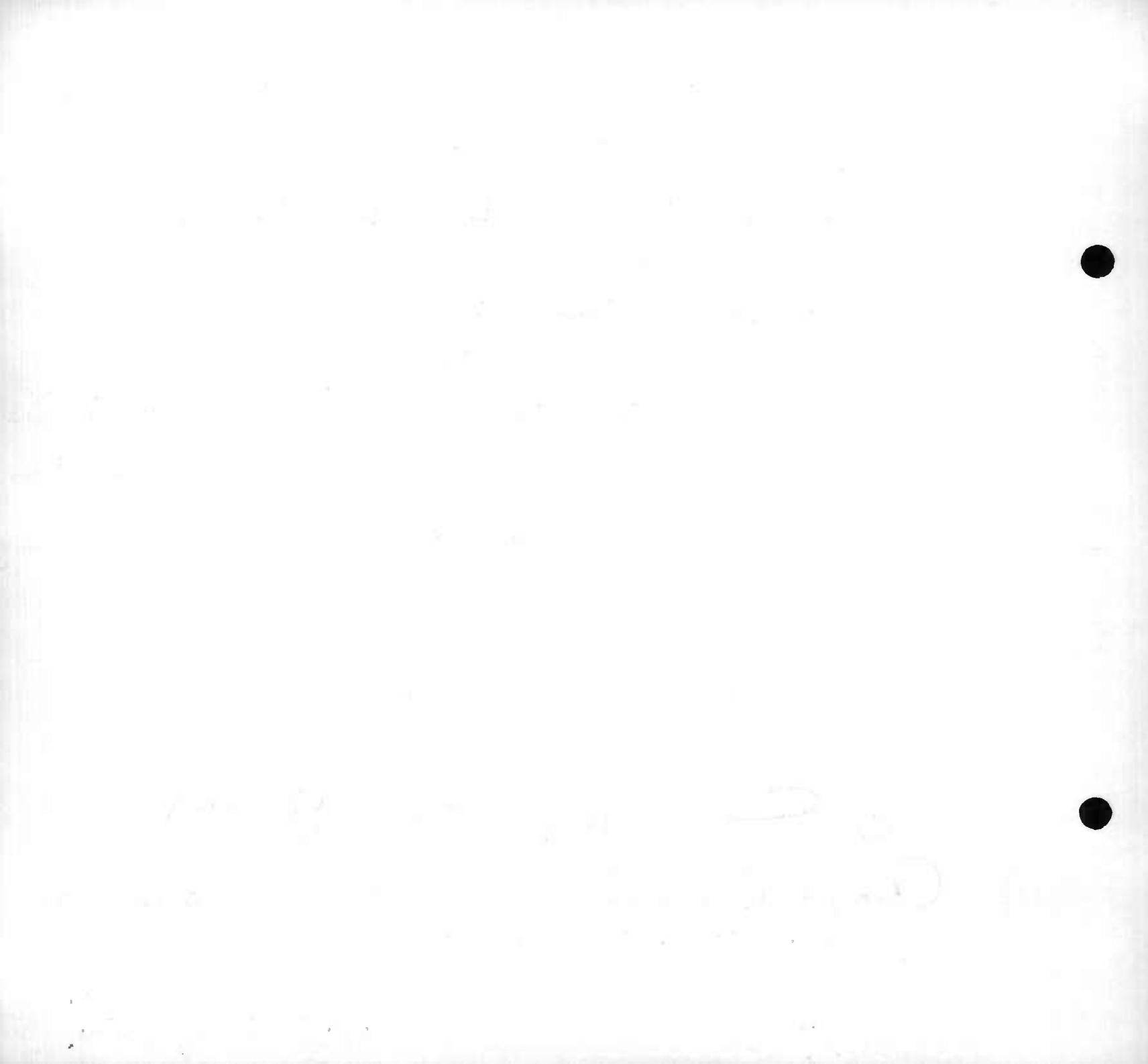
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7701</u>	
BIRTH NO. <u>70 7701</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>NELLIE G. SULLIVAN</u>			2. DATE AND HOUR OF DEATH <u>Aug. 3, 1970</u> <u>2:45</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Long Green N. H.</u>			A. STATE <u>Maryland</u> B. COUNTY <u>1202</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <u>3501 St. Paul St.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-29-82</u>	9. AGE (In years last birthday) <u>87</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Timothy F. Sullivan</u>			14. MOTHER'S MAIDEN NAME <u>Mary Girty</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		
			17. INFORMANT <u>Paul J. Plunkett, 215 Cedarcroft Rd.</u>		
			ADDRESS <u>21212</u>		
18. <u>412.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebral arteriosclerosis</u> <u>24 yr</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hypertensive arteriosclerotic CVD</u> <u>20+ yr</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this-hospital) attended the deceased from <u>Feb 20</u> 19 <u>56</u> to <u>Aug 3</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>Aug 1</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Frederick J. Vollmer</u>			23B. DATE SIGNED <u>Aug 4 1970</u>		
23C. PHYSICIAN'S NAME (Type) <u>Frederick J. Vollmer MD</u>			23D. ADDRESS <u>6100 York Rd., Balto., Md.</u>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>8-6-70</u>	24C. NAME of CEMETERY or CREMATORY <u>New Cathedral</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co., Balto., Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

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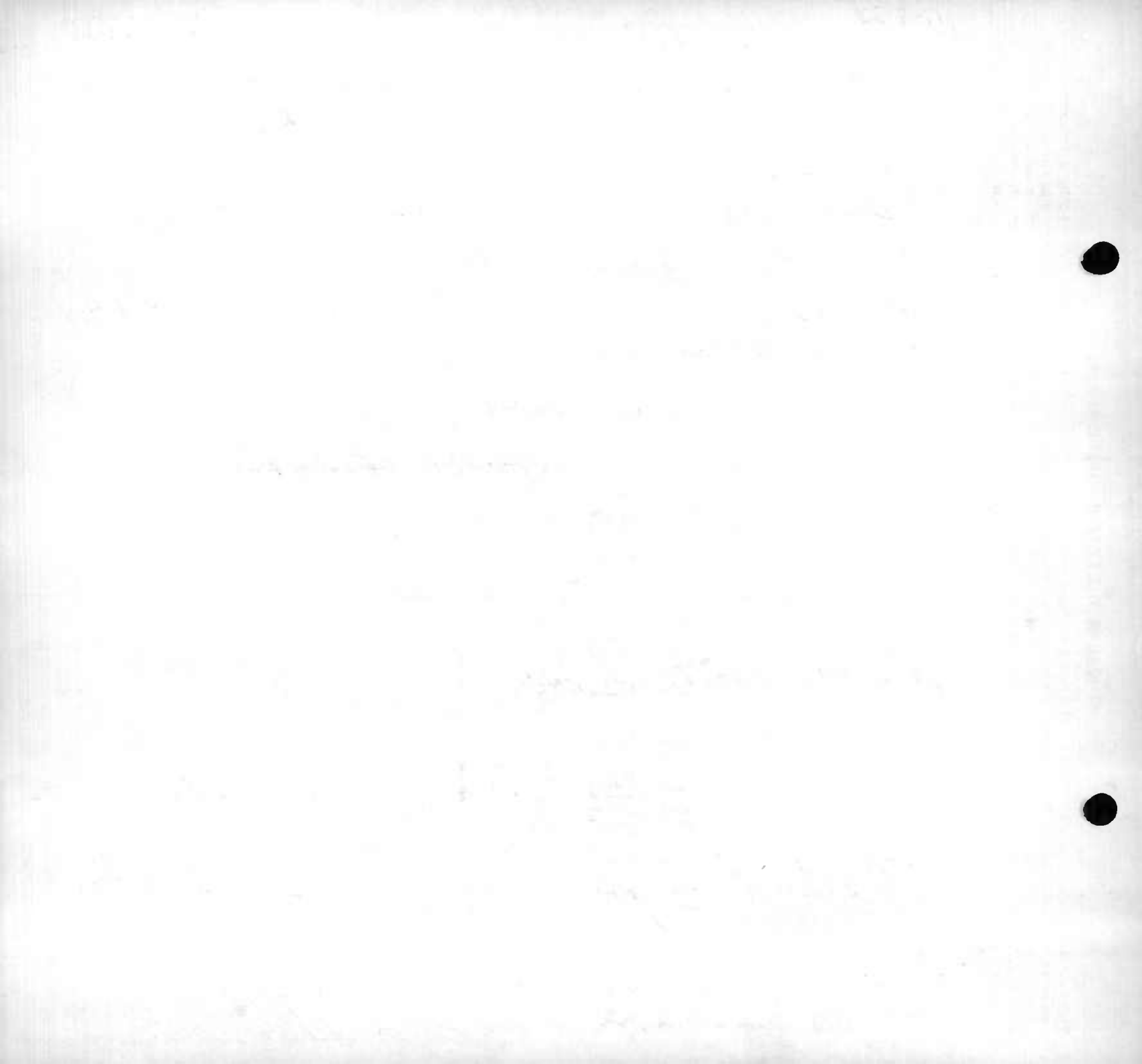
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 7702
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Alma C. Thomas		2. DATE AND HOUR OF DEATH August 1st, 1970 5 P. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived; if institution; residence before admission) A. STATE Maryland B. COUNTY 1201		
FULL NAME OF HOSPITAL OR INSTITUTION 91 Keswick 700 W. 40th Street Baltimore, Md. 21211		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-29-1888	9. AGE (In years last birthday) 82
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Housewife Home		10B. KIND OF BUSINESS OR INDUSTRY OWN		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harry E. Clark		
14. MOTHER'S MAIDEN NAME Mary Elizabeth Duffy		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 217-07-6861		17. INFORMANT NELSON, H. WINNE 5600 WOOD MONT BALTO. MD 21212		
18. 412,41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs. 8 months
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 5 Dec 19 69 to 1 Aug 19 70 that (I) (we) last saw the deceased alive on 1 Aug 19 70 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Aubrey D. Richardson		23B. DATE SIGNED 2 Aug 1970		23C. PHYSICIAN'S NAME (Type) Dr. Aubrey D. Richardson
23D. ADDRESS Keswick		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 8/4/70		24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Rd.



FUNERAL DIRECTOR: IMPORTANT

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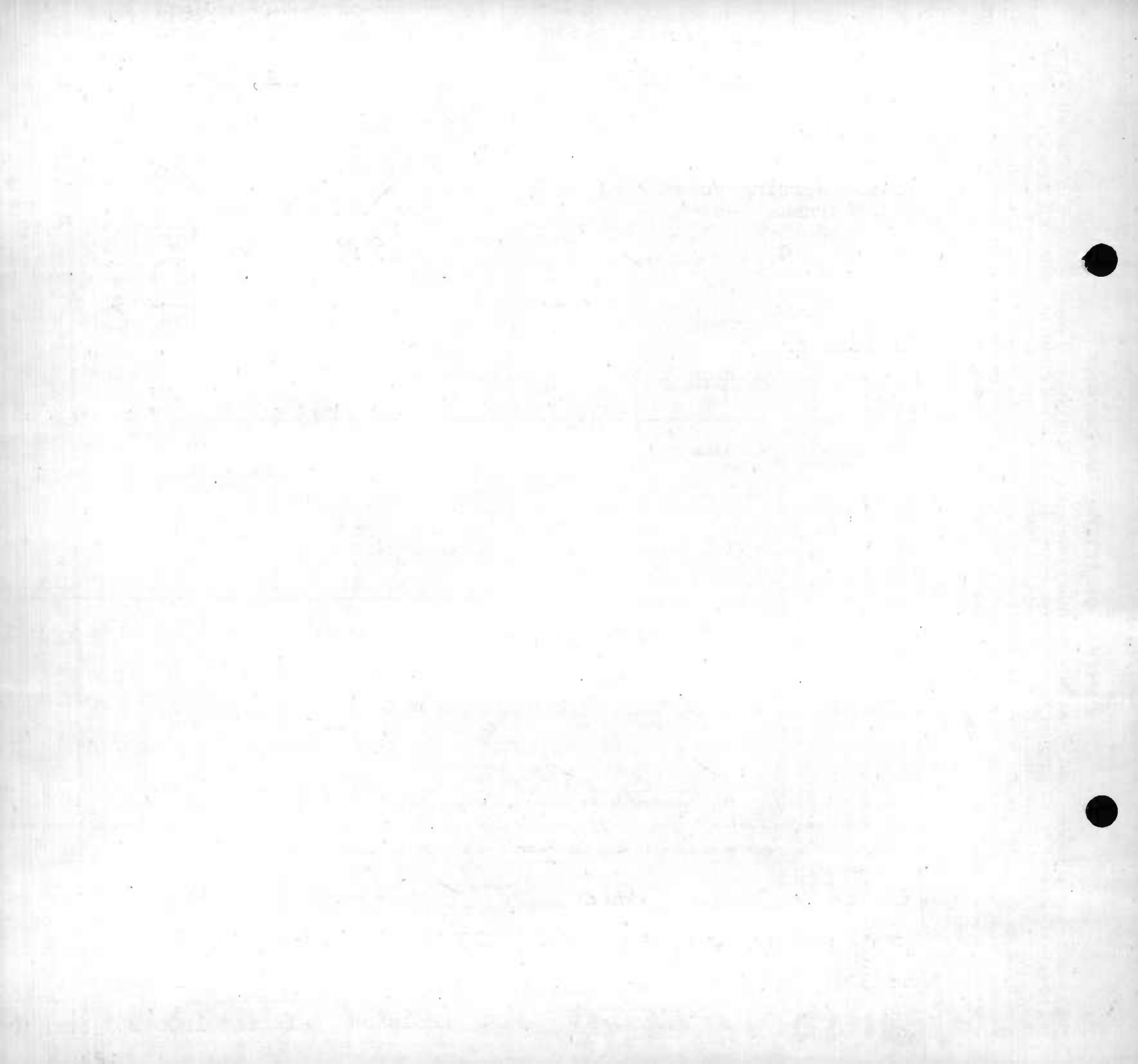
11-552		70 7703		Baltimore City Health Department		X		Registered No. 70 7703	
BIRTH NO.		M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print)		JOHN MANNING				AUG. 2, 1970 1:00 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)						A. STATE B. COUNTY			
48 MD. GENERAL HOSP. BALTO. MD.						MASS. U.S.A. V-18			
						C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
						D. STREET ADDRESS (If rural, give location)			
						169 LINCOLN ST.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
M	W	SINGLE		10-19-01	68				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RETIRED						IRELAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
RICHARD MANNING				Hannah Cronin					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
YES				017-054549					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH II DISEASE OR CONDITION CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH	
162.1 I CANCER OF LUNG									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO (B) DUE TO (C) DUE TO					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
7/30/70				CANCER OF LUNG					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/13/70 to 8/2/70, that (I) (we) last saw the deceased alive on 8/2/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Martin E. Zupke								8/2/70	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		2/7/70		Gravestone Cem.		Gravestone, Mass.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
AUG 4 1970		Robert E. Gaber, M.D.		Jesse L. Schwab, Inc.					



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 70 7704		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 7704
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
MARIA MILLER		AUGUST 2, 1970		2:15 A. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland B. COUNTY 1606		
Kenson Nursing Home 2922 Auruna Ave		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 2922 Auruna Ave		
5. SEX F	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1889	9. AGE (In years last birthday) 81
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME John Fincher		14. MOTHER'S MAIDEN NAME Sarah		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217,543,3739		17. INFORMANT Kenson Nursing Home
				ADDRESS 2922 Auruna Ave
18. 43191 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years
ANTECEDENT CAUSES		(B) Cerebral Arterio-Sclerosis		"
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Chronic Cardio-Vascular Disease		15 years
19A. DATE OF OPERATION 0 NONE	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input checked="" type="checkbox"/>		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <input checked="" type="checkbox"/>	21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <input checked="" type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from June 21, 1960 to Aug. 1, 1970, that (I) (we) last saw the deceased alive on Aug. 1, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Frank N. Ogden, M.D.		23B. DATE SIGNED Aug 3, 1970		
23C. PHYSICIAN'S NAME (Type) FRANK N. OGDEN, M.D.		23D. ADDRESS 2701 N. CALVERT ST. Baltimore Md. 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/6/70	24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W. North Ave		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

PAULINE E. CLARK

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

July 29, 1970

5:00 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 Lutheran Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

July 29, 1970

5:00 P. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Balto. 5300

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

C. CITY OR TOWN

Glyndon Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

Jan. 16, 1924

10. AGE (In years
lost birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

29 Chatsworth Avenue

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Austin Ambrose

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Dessie Grimes

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

215-38-0088

18. INFORMANT

Mr. John Clark

ADDRESS

Glyndon, Md.

19. 431.9

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Massive intracerebral hemorrhage

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 30, 1970

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

August 1, 1970 Evergreen Memorial

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

Finksburg, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 4 1970

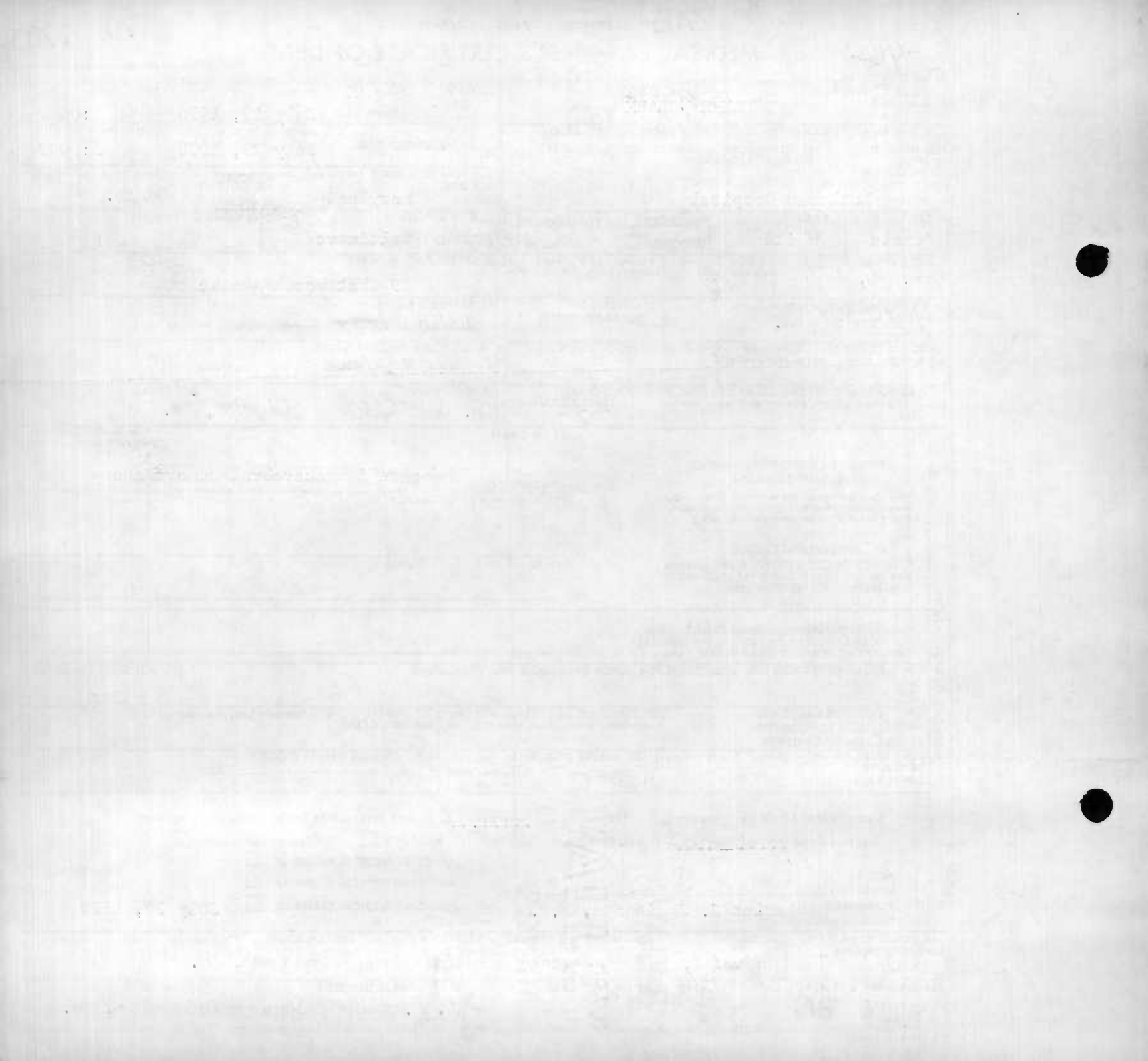
25B. NAME OF REGISTRAR

Robert E. Vickers, Jr.

25C. FUNERAL DIRECTOR

J. F. Eline & Sons Reisterstown, Md.

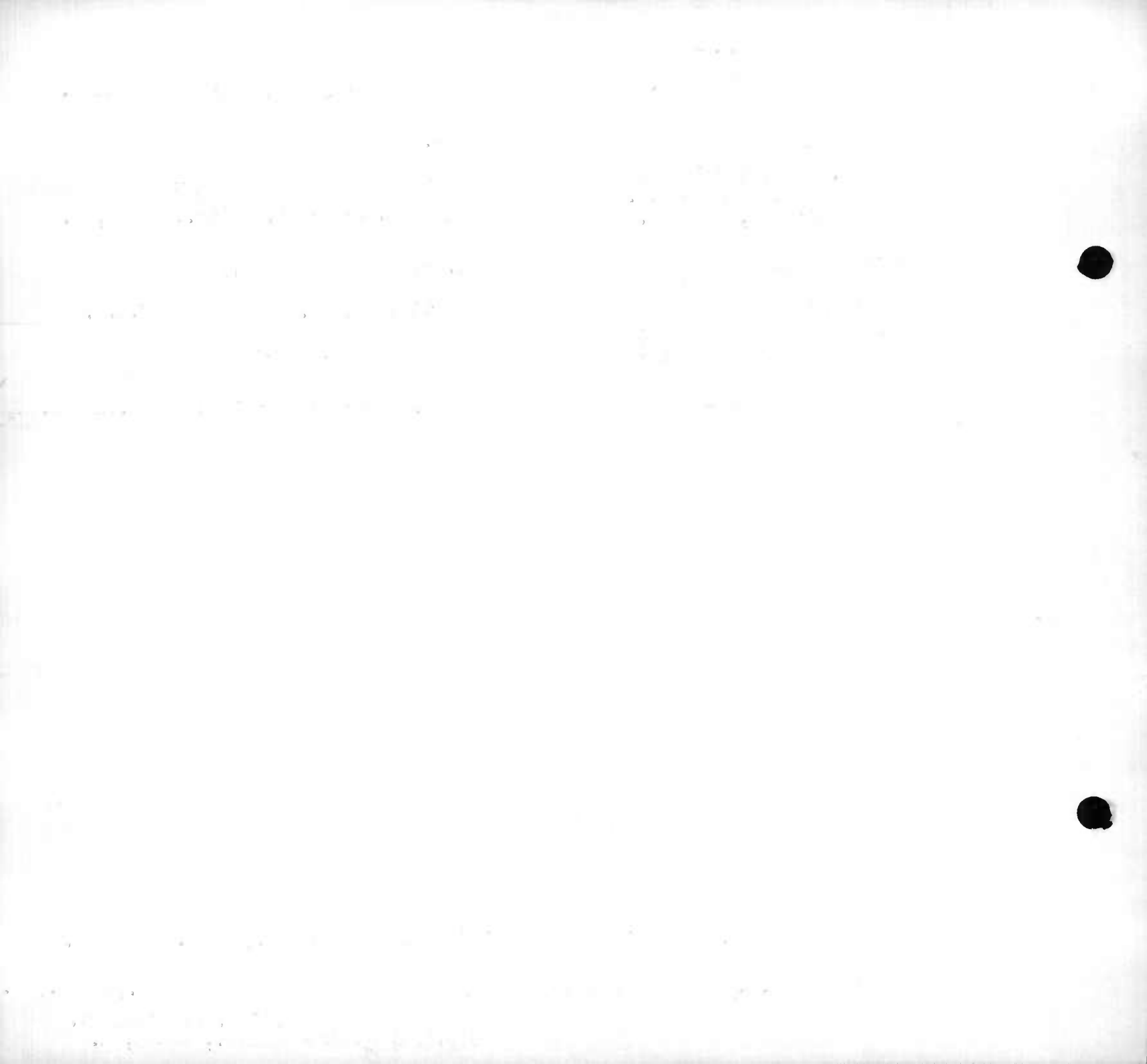
ADDRESS



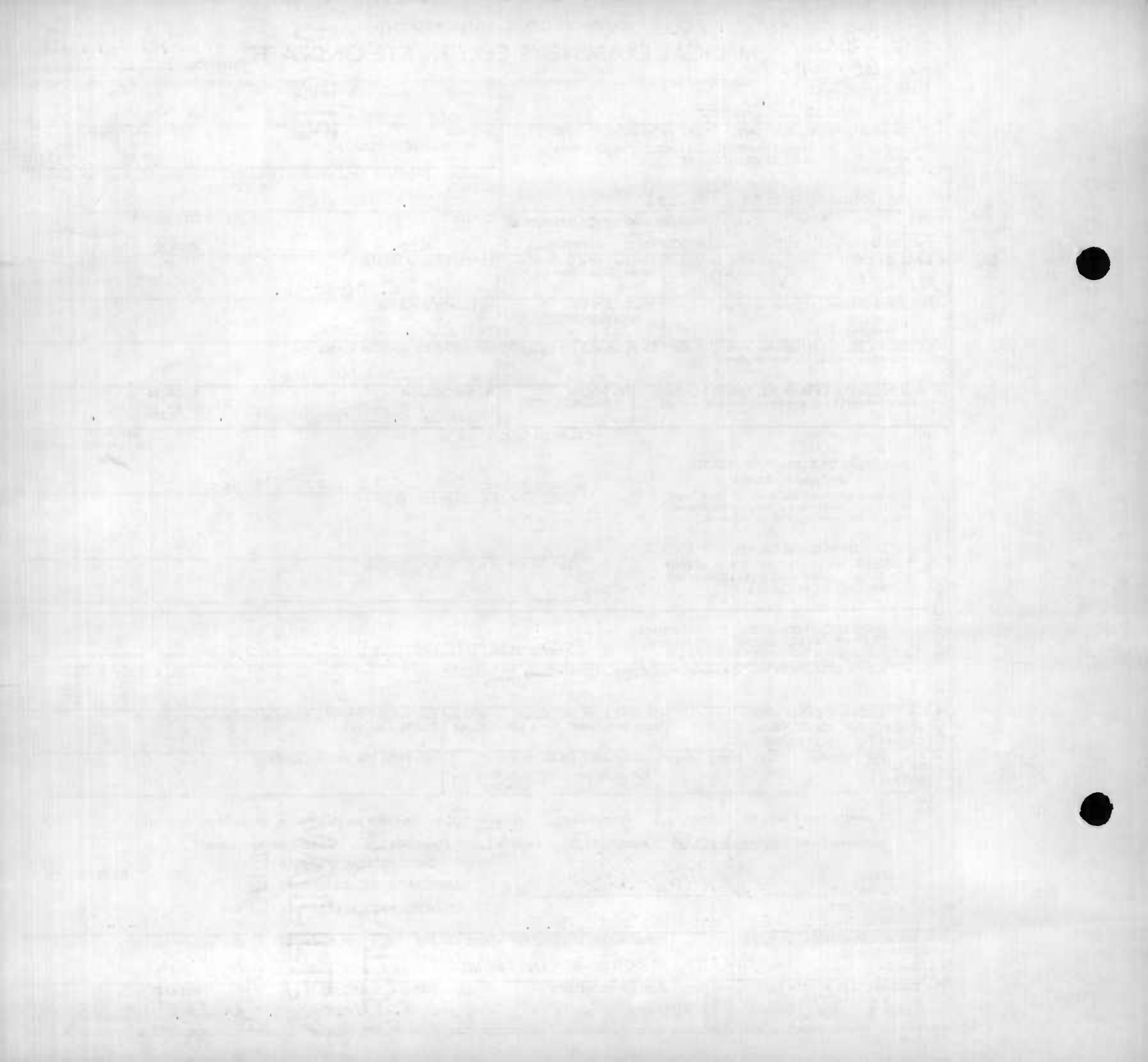
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7706</u>	
4-246 BIRTH NO. <u>70 7706</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>ANNIE L. HESSIER</u>		2. DATE AND HOUR OF DEATH <u>July 30, 1970</u> <u>11:45 A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital or institution, give street address or location) <u>Mt. Sinai Nursing Home</u> <u>4613 Park Heights Ave.</u> <u>Baltimore, Md.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>301</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>290 Dallas Court., Balto., 21231, Md.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 12, 1890</u>	9. AGE (In years last birthday) <u>79</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>House Work</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William West</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Egan</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Elsie W. Saylor ; 4116 Century Rd., Balto., Md.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebro Vascular Acc</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebro Vascular Acc</u> (B) <u>ASCVD</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, public bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/27</u> 19 <u>70</u> to <u>7/30</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>7/30</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Edward S. Kallins</u>		23B. DATE SIGNED <u>8/1/70</u>		23C. PHYSICIAN'S NAME (Type) <u>EDWARD S. KALLINS</u>	
23D. ADDRESS <u>6000 Park Heights Ave., Balto., Md.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>8-3-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>5501 Frederick Ave., Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Jaber, Md.</u>		25C. FUNERAL DIRECTOR <u>Charles S. Gailer</u>	
25D. ADDRESS <u>901 S. Conkling St. Balto., 21224, Md.</u>					



BALTIMORE CITY HEALTH DEPARTMENT				70 7708
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.
1. NAME OF DECEASED (Type or Print) <i>D. Michelle Shiner</i>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>33 Johns Hopkins Hospital</i>		3. DATE PRONOUNCED DEAD Month Day Year Hour <i>8 1 1970 2:56 P.M.</i>		
6. SEX Female		7. RACE White		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>2636</i>
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <i>Balto.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <i>11/10/69</i>		10. AGE (In years last birthday) <i>8</i>		E. STREET AND NUMBER <i>5020 E. Oliver St.</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>David G. Shiner</i>
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <i>Constance Ruth Burns</i>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT <i>David G. Shiner</i>
				ADDRESS <i>5020 E. Oliver St.</i>
19. <i>7769</i> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE Congenital heart disease DUE TO, OR AS A CONSEQUENCE OF:
				(B) DUE TO, OR AS A CONSEQUENCE OF:
				(C) DUE TO, OR AS A CONSEQUENCE OF:
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Down's syndrome (mongolism)</i>				
20A. DATE OF OPERATION <i>2</i>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <i>yes</i>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <i>Isidore Mihalakis, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>8-2-70</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/4/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Bohemian National Cemetery Baltimore, Maryland</i>
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 4 1970</i>		
25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>John A. Moran, Inc.</i>		
		ADDRESS <i>3000 E. Baltimore S</i>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

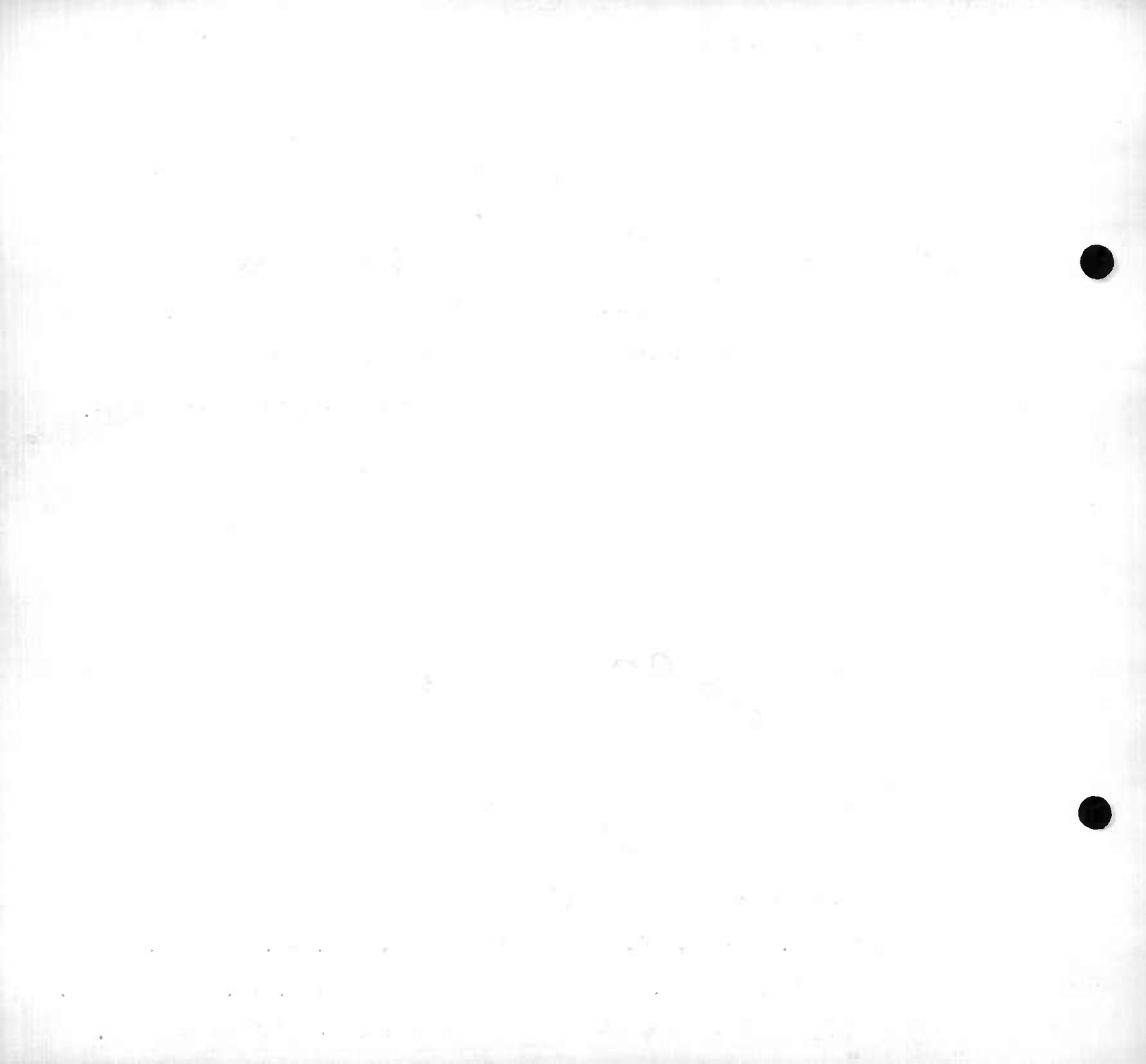
BIRTH NO. M-240		70 7707		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7707	
1. NAME OF DECEASED (Type or Print) McGill, James T.				2. DATE AND HOUR OF DEATH 7/31/70 3:35 p.m. P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hosp. Baltimore, Md.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland - B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3213 ST Paul Street			
5. SEX M	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/21/06	9. AGE (in years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk			10B. KIND OF BUSINESS OR INDUSTRY Goetz Meat Packing Co. Maryland			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis McGill			14. MOTHER'S MAIDEN NAME Margaret O'Donovan				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-76-3282		17. INFORMANT Mary Miles ADDRESS 1712 Dartmouth Ave Baltimore, Md		
18. 189.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Hypernephroma DUE TO, OR AS A CONSEQUENCE OF: (B) Melastasis to lung, adrenal DUE TO, OR AS A CONSEQUENCE OF: (C) liver & other organs				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I A1.							
19A. DATE OF OPERATION 7/26/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5:35 p.m. 7/26/70 to 3:35 p.m. 7/31/70 that (I) we last saw the deceased alive on 3:30 p.m. 7/31/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) we did (did not) view the body after death.							
23A. SIGNATURE H. Earl Cotman M.D.				23B. DATE SIGNED 7/31/70		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) H. EARL COTMAN, M.D.				23D. ADDRESS Union Memorial Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/4/70		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Farber, R.D.		25C. FUNERAL DIRECTOR ADDRESS John A. Moran, Inc. 3000 E. Baltimore St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7709	
BIRTH NO. 8-400 70 7709		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Lillian V. Seal</i>		2. DATE AND HOUR OF DEATH <i>Aug. 2, 1970 12:05 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>44 Union Memorial Hosp</i>		A. STATE <i>Maryland</i>		B. COUNTY <i>Baltimore</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>1113 W. 36th Street</i>			
5. SEX <i>F</i>	6. RACE <i>Can</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/28/24</i>	9. AGE (In years last birthday) <i>75</i>	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>Peter Walker Broyles</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Taylor</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT ADDRESS <i>Wayne Williams-855 Arnelcliffe Rd.</i>	
18. <i>4-10-71</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>CARDIAC ARREST</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Acute Myocardial Infarct</i> DUE TO, OR AS A CONSEQUENCE OF: (C) -----		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>July 31</i> 19 <i>70</i> to <i>Aug 2</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>Aug 2</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David J. Powner, M.D.</i>		23B. DATE SIGNED <i>Aug 2, 1970</i>		23C. PHYSICIAN'S NAME (Type) <i>David J. Powner, M.D.</i>	
23D. ADDRESS <i>Union Mem. Hosp. - 1113 W. 36th St.</i>		23E. DEGREE <i>M.D.</i>		23F. FUNERAL DIRECTOR ADDRESS <i>Ann Donovan - 3818 Roland Ave.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/5/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Carmel Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Co., Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>AUG 4 1970</i>		24F. NAME OF REGISTRAR <i>Robert E. Taylor, R.D.</i>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 7710

BIRTH NO.

1. NAME OF DECEASED Christofaro (Cristofero)
(Type or Print) CHRISTIAN CURRIERI2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

3. DATE PRONOUNCED DEAD Month Day Year Hour
7 31 1970 10 P. M.FULL NAME OF DECEASED (If not in hospital or institution, give street address and city and state)
CERTIFICATE AMENDED

00 31 E. Hamburg St. 8-10-70

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md. B. COUNTY 2302

6. SEX

7. RACE

8. MARRIED ☐ NEVER MARRIED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Male

White

WIDOWED ☐ DIVORCED ☐

Balto.

YES ☒ NO ☐

9. DATE OF BIRTH

10. AGE (In years last birthday)

If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

#3/23/1881

89

31 E. Hamburg St.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Italy

Antonio

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Stonemason

Building

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No17. SOCIAL SECURITY NO.
219-22-407518. INFORMANT ADDRESS 21212
Joseph C. Sortino 1220 E. Belvedere Ave.

19. 412.4

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐NOT WHILE AT WORK ☐

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-1-80

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

8/1/1970

Holy Redeemer Cemetery

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

AUG 4 1970

Robert E. Taylor, R.A.

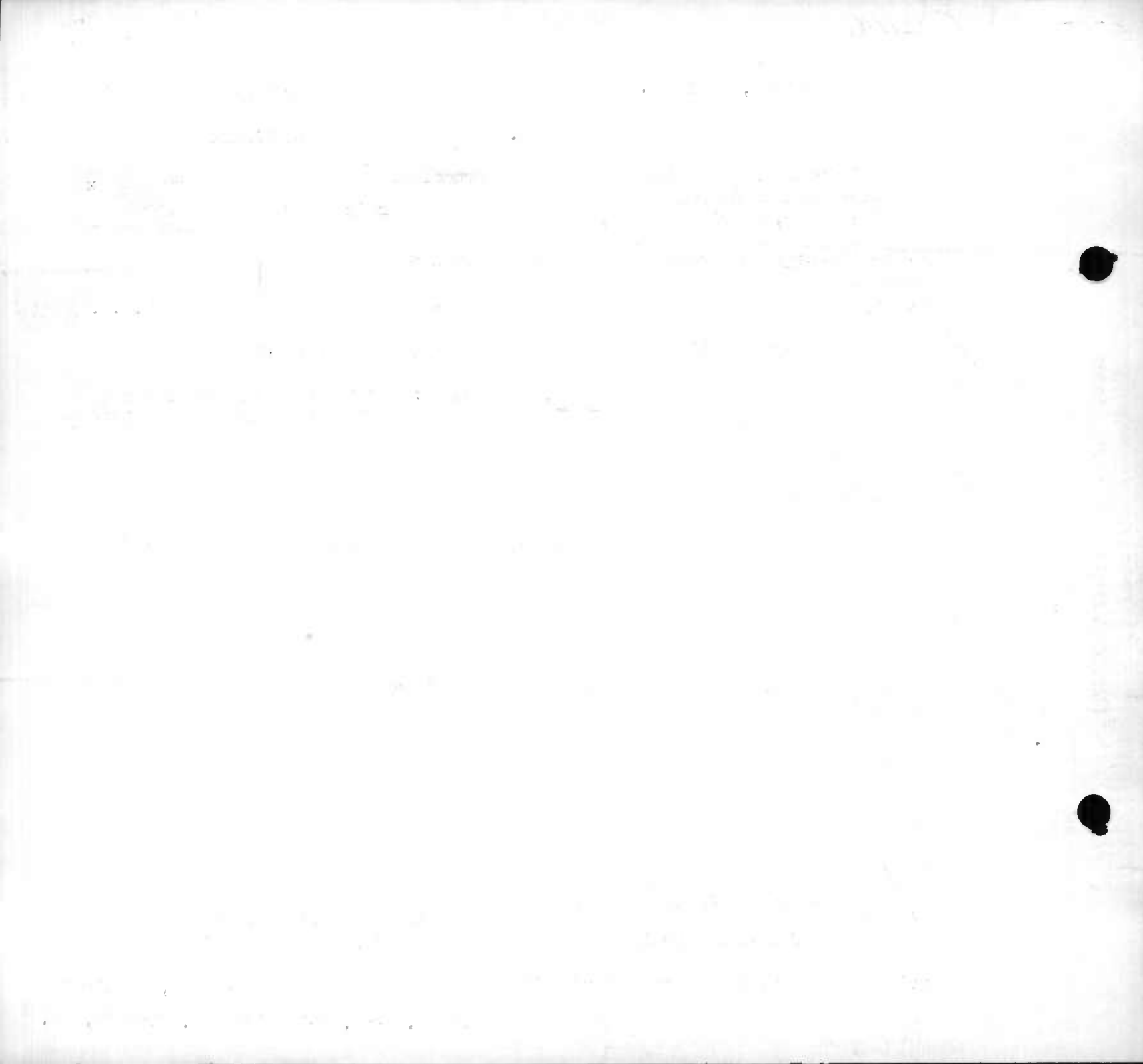
McCully Funeral Home 130 E. Fort Ave. 21230

CRIMINAL MENDED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		70 7711	
BIRTH NO.				70 7711		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Oliver, Marie M.				8/2/20 4:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland				Maryland		Baltimore	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER			
				6519 Detroit Avenue		#21222	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4-13-02	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
68		Housewife		Pennsylvania		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Guy Cornell				Florence Lescalett			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		215-50-6853		Records: Baltimore City Hospitals		4940 Eastern Avenue #21224	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Uremia			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Chronic Pyelonephritis			
				13 yrs.			
				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
No		No		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
No							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8/1 1970 to 8/2 1970 that (I) (we) last saw the deceased alive on 8/2 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Jereniah Duwel				8/2/20			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Jereniah Duwel				Baltimore City Hospitals			
				4940 Eastern Avenue		#21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION	
Burial		8/6/70		Gardens of Faith Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 4 1970		Robert E. Fisher, M.D.		John J. Duda		7922 Wise Ave. Dundalk, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

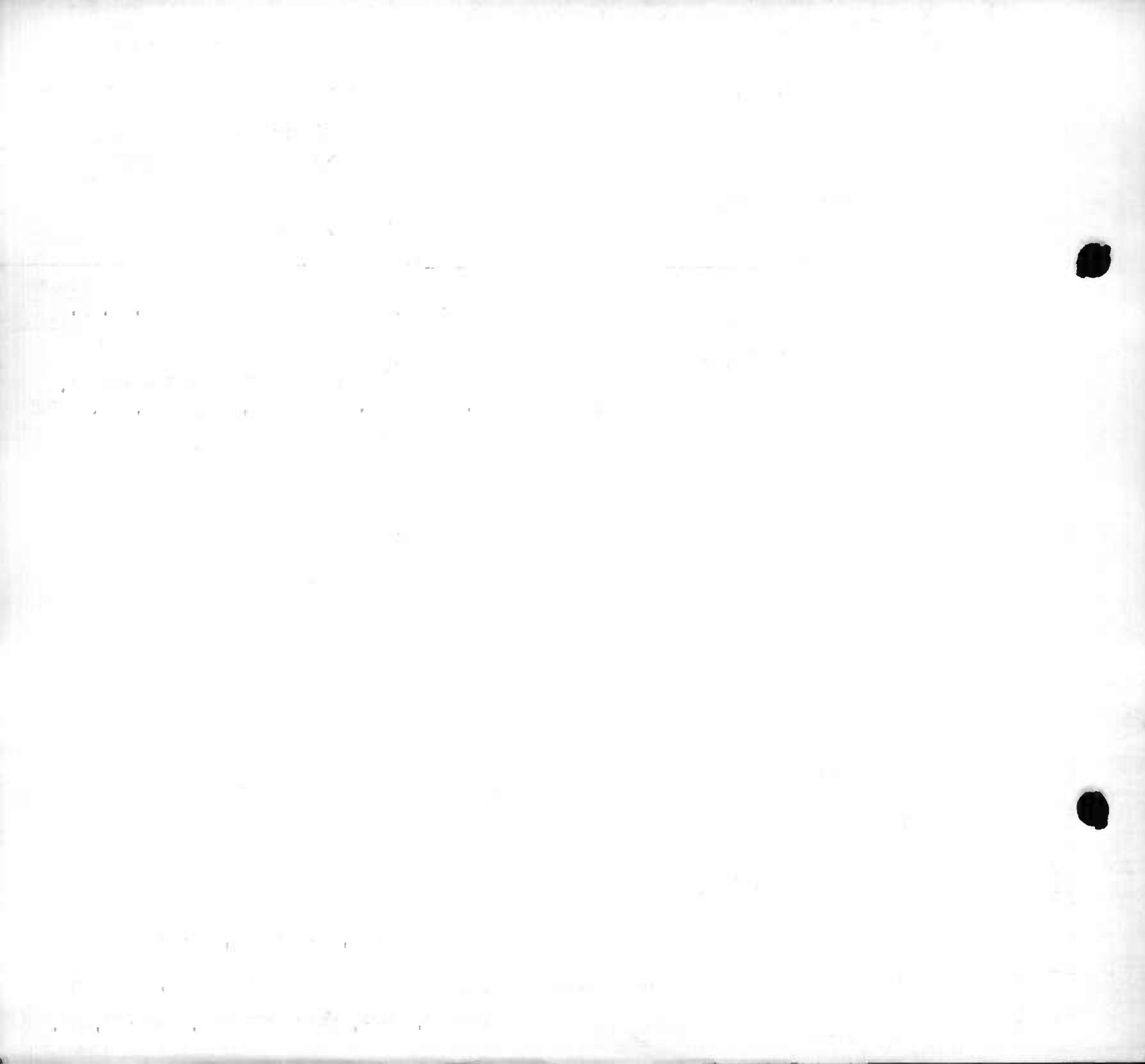
B-636 70 7712		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 7712	
1. NAME OF DECEASED (Type or Print) BESSIE FLORENCE BARTRAM		2. DATE AND HOUR OF DEATH Aug 1st 1970 5:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 43 SOUTH BALTIMORE GENERAL HOSPITAL South Baltimore General Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN Sparrows Point D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Rt. 10, Box 317x, Wood Ave.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-27-88	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME ISAAC P. HAMRICK (dec)		14. MOTHER'S MAIDEN NAME SARAH DAVIS (dec)		12. CITIZEN OF WHAT COUNTRY U.S.A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 01-28-7107		17. INFORMANT ERLA C. WEBB (daughter) ADDRESS Rt. 10, Box 317x BALTO COUNTY MD 21219	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 009.21		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Gastro-enteritis.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hypertensive Cardio-vascular disease. DUE TO, OR AS A CONSEQUENCE OF: 20 yrs.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II		(C) Diabetes mellitus 20 yrs.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2:30 P.M. August 1, 1970 to 5:00 P.M. August 1, 1970 that (I) (we) last saw the deceased alive on 5:00 P.M. August 1, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Angelina		23B. DATE SIGNED 8/1/70		23C. PHYSICIAN'S NAME (Type) DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/70		24C. NAME of CEMETERY or CREMATORY Meadowridge Memorial Park	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John J. Duda ADDRESS 7922 Wise Ave. Dundalk, Md.	
24D. LOCATION (City, town, or county) (State) Dorsey, Maryland					



FUNERAL DIRECTOR: IMPORTANT

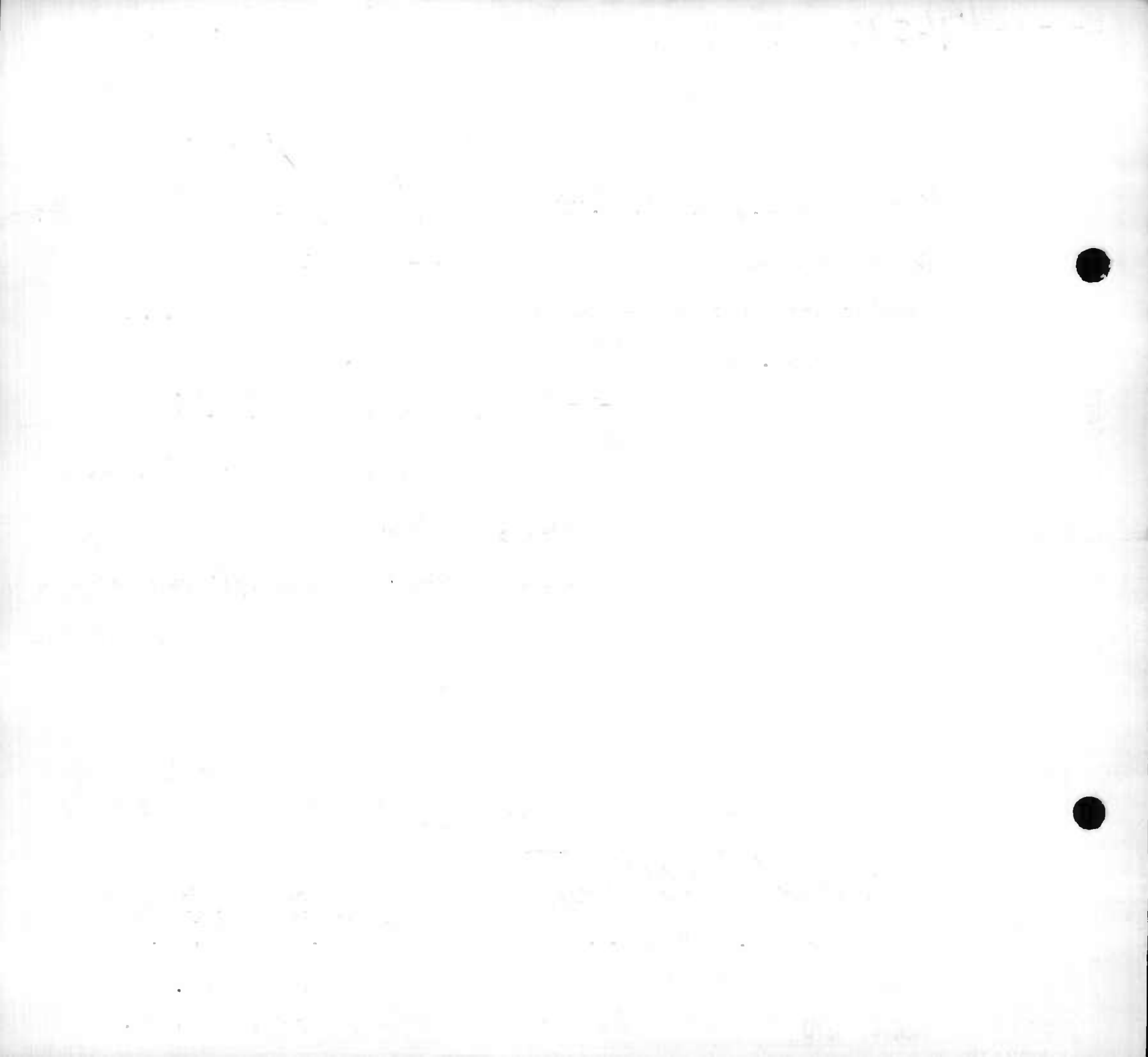
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-452 70 7713		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
Sally Anne Killinger		8-3-70 9:05 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
37 Mercy Hospital		Md Baltimore 5300	
5. SEX		C. CITY OR TOWN	
F W		Dundalk	
6. RACE		D. INSIDE CITY LIMITS?	
W		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER	
8. DATE OF BIRTH		7712 Charlesmont Rd	
9. AGE (In years lost birthday)		6-14-61 9	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
10B. KIND OF BUSINESS OR INDUSTRY		Balto, Md	
12. CITIZEN OF WHAT COUNTRY?		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Robert Killinger		Harriet Sheppard	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		None	
17. INFORMANT (Father) 7712 Charlesmont Rd.		Mr. Robert R. Killinger, Dundalk, Md. 21222	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Cardio-Respiratory arrest	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: asphyxia(?)	
ANTECEDENT CAUSES		(B) Respiratory distress & U.R.-I DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Psychomotor retardation	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 2nd 1970 to Aug. 3rd 1970 that (I) (we) last saw the deceased alive on Aug. 3rd 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
YAL		8/3/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
DEGREE		Mercy Hospital, Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		8/5/70	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Sacred Heart of Jesus		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
AUG 4 1970		Robert E. Jarboe, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	
John J. Duda		7922 Wise Ave. Dundalk, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7714	
BIRTH NO.		70 7714		70 7714	
1. NAME OF DECEASED (Type or Print) <u>Walter Peddle</u>		2. DATE AND HOUR OF DEATH <u>7/30/70 12:35 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> 4940 Eastern Ave. Baltimore, Md. 21224		A. STATE <u>Maryland</u> , B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1043 Hignet Way</u> 21205 007			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-89</u>	9. AGE (in years last birthday) <u>81</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John B. Peddle</u>			
14. MOTHER'S MAIDEN NAME <u>Sally C. Gross</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>213-14-3560</u>		17. INFORMANT <u>BCH Records: Baltimore, Md. 21224</u>			
18. <u>519.217-320.9</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Probable Pneumococcal Meningitis</u>		<u>24 hours</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Pneumococcal pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>3 days</u>	
(C) <u>Chronic Obstructive Lung Disease</u>				<u>>10 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Arrhythmia, Fibrillation, hypertension, Diabetes Mellitus</u>			
19A. DATE OF OPERATION <u>7/29</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>Yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7/29 1970</u> to <u>7/30 1970</u> and that (I) (we) last saw the deceased alive on <u>7/30 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Howard S. Goldberg, M.D.</u>		23B. DATE SIGNED <u>7/30/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Howard S. Goldberg M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/3/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	
24D. LOCATION <u>Baltimore, Md.</u>		24E. ADDRESS <u>4940 Eastern Ave. Baltimore, Md. 21224</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7715</u>	
K-610		70 7715		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ELLADENE MAE ELLA KIRBY		2. DATE AND HOUR OF DEATH 7/31/70 12:30 AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY		2642	
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4725 CHATFORD AVENUE		5. SEX F 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-5-24 9. AGE (In years lost birthday) 46	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat wrapper		10B. KIND OF BUSINESS OR INDUSTRY Eddie's Supermarket		11. BIRTHPLACE (State or foreign country) W. Va.	
13. FATHER'S NAME CHARLES MAYFIELD		14. MOTHER'S MAIDEN NAME REGINA HAWKINS		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Albert Kirby, husband, above	
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) GI Hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Metastatic Carcinoma of the Breast		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 10 yrs	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from July 31 1970 to July 31 1970 , that (we) lost saw the deceased alive on July 31 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael Allen Moore, MD		23B. DATE SIGNED 7/31/70		23C. PHYSICIAN'S NAME (Type) MICHAEL ALLEN MOORE	
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/3/70	
24C. NAME of CEMETERY or CREMATORY Moreland Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970	
25B. NAME OF REGISTRAR Robert E. Tabor, MD		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-651 70 7716				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7716	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>C. Charles Greenborn</u>				2. DATE AND HOUR OF DEATH <u>July 29, 1970</u> <u>10:05 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37 Mercy Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>841</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3106 Lawnview Ave</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-3-98</u>	9. AGE (In years last birthday) <u>72</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automotive Clerk</u>		
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>Gustav Augusta Greenborn</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Wachter</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>Army WW 1</u> <u>215-10-6506</u>				16. SOCIAL SECURITY NO. <u>215-10-6506</u>			
17. INFORMANT <u>Elizabeth Greenborn, wife, above</u>				ADDRESS			
18. <u>412.4 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE Intra-aortic Aneurysm</u> <u>(B) ASCVD and Pulmonary Embolism</u> <u>(C)</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Specify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>July 11</u> 19 <u>70</u> to <u>July 29</u> 19 <u>70</u> and that (I) (we) last saw the deceased alive on <u>July 29</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>C. Vergara M.D.</u>				23B. DATE SIGNED <u>July 29, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>CORAZON Z. VERGARA, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>8/3/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore National Cem.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 4 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>	
				25D. ADDRESS <u>3331 Brehms Lane</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7717	
K-246 70 7717		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		FRANK I. KESSELRING		2. DATE AND HOUR OF DEATH July 30, 1970 3 p.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Md. 21224		B. COUNTY	
00 2810 Orleans Street		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2810 Orleans Street			
5. SEX male	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/18/83	9. AGE (In years last birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-09-0806		17. INFORMANT Margaret Kesselring, dght. above	
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Hypertension C.V. Disease with Hemiplegia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) V. Disease with Hemiplegia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7-29-70 1962	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). None					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) None	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) None		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? None	
22. I certify that (I) (this hospital) attended the deceased from July 27 1962 to July 30 1970 that (I) (we) last saw the deceased alive on 7-30-70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE E. A. Schimunek				23B. DATE SIGNED 7-30-70	
23C. PHYSICIAN'S NAME (Type) Dr. E. A. Schimunek		23D. ADDRESS 842 S. East Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/3/70		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	
24D. LOCATION Baltimore, Md.		24E. NAME OF CEMETERY OR CREMATORY Baltimore, Md.		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601 E. Madison St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-550 70 7718		BALTIMORE CITY HEALTH DEPARTMENT		70 7718	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Elizabeth Bowman		2. DATE AND HOUR OF DEATH July 29/1970 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland - Baltimore City			
FULL NAME OF HOSPITAL OR INSTITUTION D.O.A. Lutheran Hosp. Pul		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3616 W. Farnes St. Apt. 1538			
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/1/1907	9. AGE (In years lost birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) South Boston, Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-09-2893		17. INFORMANT Mrs Frances G. Gumb - 4400 Farnes Ave	
18. 412.2.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CVA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive C-V Disease		Unknown	
		(B) DUE TO, OR AS A CONSEQUENCE OF: Cardiac Decompensation		2 weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/29 19 70 to 7/24 19 70, that (I) (we) last saw the deceased alive on 7/23 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. E. Holt, M.D.		23B. DATE SIGNED 7/30/70			
23C. PHYSICIAN'S NAME (Type) E. E. Holt, M.D.		23D. ADDRESS 3715 Liberty Hgts. Ave. Balt. more, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/3/70		24C. NAME OF CEMETERY or CREMATORY Crown Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR L. J. Canell - 1712 W. North Ave		25D. ADDRESS			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Viola Marvin		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 31 70 8:55 a. m.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1503		6. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. SEX female	7. RACE colored	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 1/6/21	10. AGE (In years last birthday) 49	E. STREET AND NUMBER 2539 W. North Ave.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laboratory Assistant		13. FATHER'S NAME Olden Griffin	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Rosie Diamond	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212-22-4230	
18. INFORMANT Rosie Diamond		ADDRESS 2539 West North Avenue	
19. 430.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Spontaneous subarachnoid hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 7		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 7/31/70 DATE SIGNED			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/4/70	24C. NAME OF CEMETERY or CREMATORY Baltimore National	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. AUG 4 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 North Monroe St.	

ACADEMIC BOARD

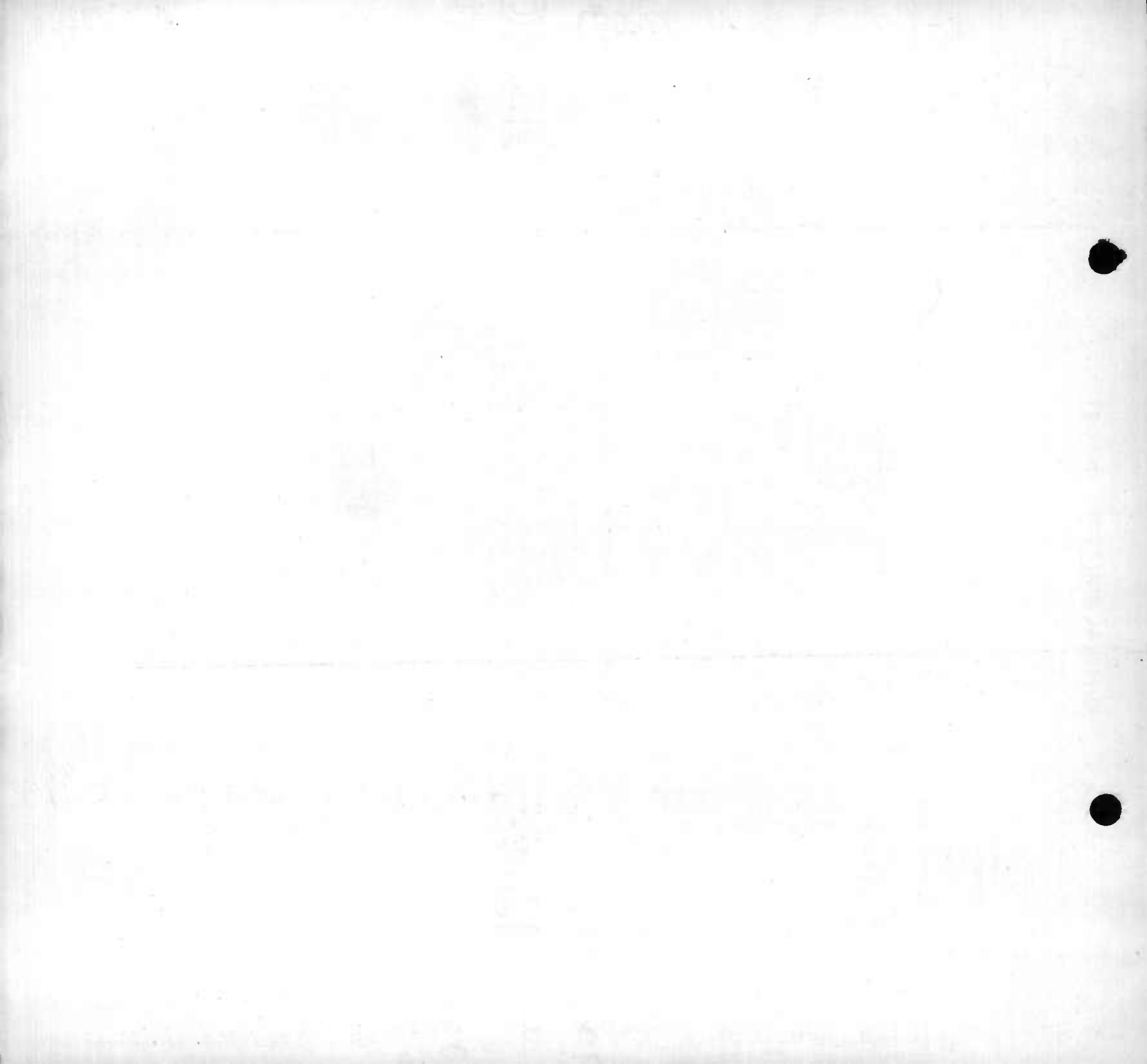
MEMBERS

1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7720	
BIRTH NO. 4-200		70 7720 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Katherine W. Hess			2. DATE AND HOUR OF DEATH Aug. 1, 1970 1:00 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green Nursing Home 115 Melrose Avenue Baltimore, Md. 21212			A. STATE Maryland 21218 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2804 Maryland Avenue		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9, 1886	9. AGE (In years lost birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY Banking		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME William Caufil Woods		
14. MOTHER'S MAIDEN NAME Marian Craumer			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 216-07-0948A			17. INFORMANT Bertha W. Woods (Sister) Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 412.4 I Intestinal Hemorrhage			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arterio Sclerotic Cardio Vascular Disease (B) DUE TO, OR AS A CONSEQUENCE OF: Disease (C) _____		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 1969 to 8/1/70 that (I) (we) last saw the deceased alive on July 31 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. George McLean			23B. DATE SIGNED Aug 3-70		23C. PHYSICIAN'S NAME (Type) Dr. George McLean
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE Aug. 4, 1970		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery
24D. LOCATION Baltimore, Md.			24E. ADDRESS Medical Art Building Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Eugenia K. Seitz 5209 York Rd. Seitz Funeral Home Balto. Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Z-460		70 7721		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH X		REG. NO. 770 7721	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) ZELLER, MABEL E.				2. DATE AND HOUR OF DEATH Aug 2, 1970 5:45 AM.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HARBOR VIEW NURSING HOME				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1244 MAPLE AVENUE 21227					
5. SEX F		6. RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-12-86		9. AGE (in years last birthday) 84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRESSMAKER				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME SIMMONDS, JAMES				14. MOTHER'S MAIDEN NAME RHINE, REBECCA					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220-46-4456		17. INFORMANT ADDRESS			
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral thrombosis & left hemiplegia (B) antenatal & postnatal DUE TO, OR AS A CONSEQUENCE OF: (C) arteriosclerosis per				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7/70 years years	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/2 19 69 to 8/2 19 70 that (I) (we) last saw the deceased alive on 8/2 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE [Signature]				23B. DATE SIGNED 8/2/70				23C. PHYSICIAN'S NAME (Type) ALLAN H. MARCH MD	
23D. ADDRESS 2 E Red St Baltimore Md 21202				24A. BURIAL CREMATION, REMOVAL (Specify) Burial					
24B. DATE Aug 5 1970				24C. NAME OF CEMETERY or CREMATORY Landon Park		24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR [Signature] 13218 Sulphur Sp. Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

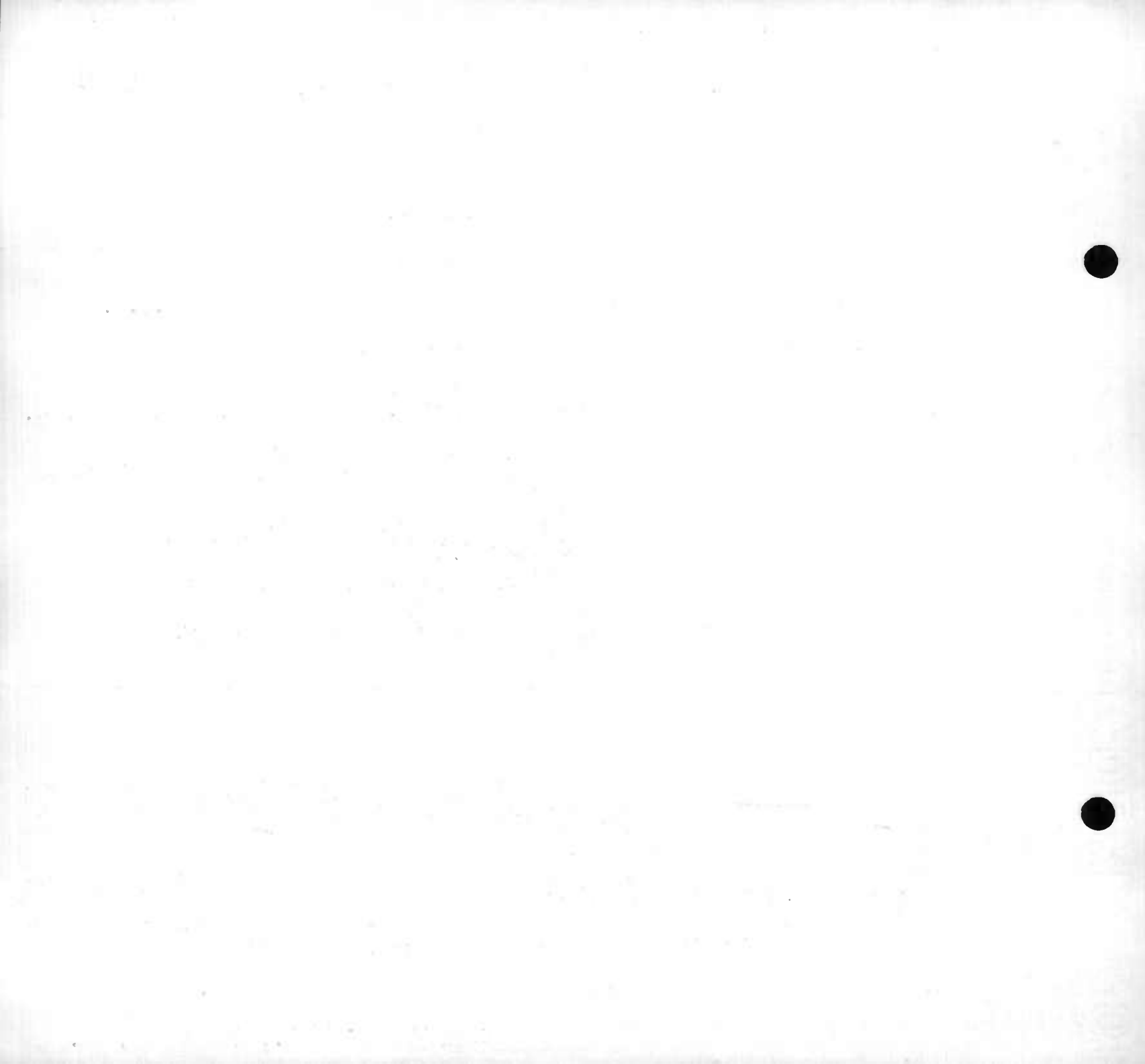
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7722	
M-222		70 7722		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Anna L. Makauskas		2. DATE AND HOUR OF DEATH 8/2/70 945 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1803			
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hosp.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 811 Hollins St.					
5. SEX F.	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/1891	9. AGE (In years last birthday) 78	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Lithuania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ✓		17. INFORMANT Mr. John Makauskas	
ADDRESS above		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction, recurrent (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic CVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden			
19. DATE OF OPERATION 8/10/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Aug 25 1969 to August 2 1970 that (I) (we) lost saw the deceased alive on March 20 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Herbert J. Levic		23B. DATE SIGNED 8/3/70		23C. PHYSICIAN'S NAME (Type) Herbert J. Levic	
23D. ADDRESS 5404 East Drive		23E. DATE 8/6/70		23F. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	
23G. LOCATION Baltimore		23H. DATE REC'D BY HEALTH DEPT. AUG 5 1970		23I. NAME OF REGISTRAR Robert E. Tabor	
23J. FUNERAL DIRECTOR John J. Gorman & Son Inc.		23K. ADDRESS 901 Hollins St.		23L. DATE 8/2/70	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

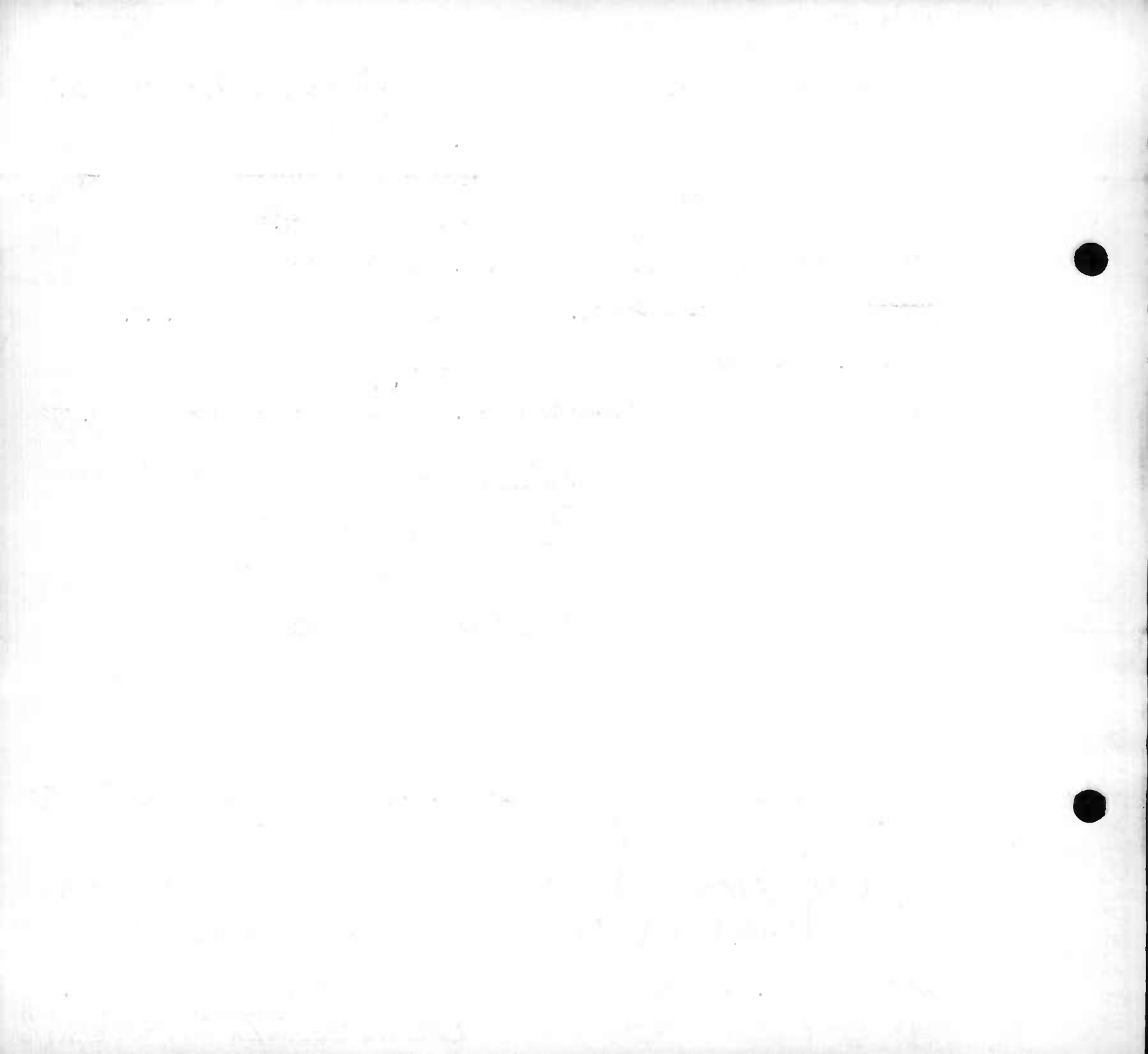
W-650		70 7723		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7723	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) NELLIE J. WAREHIME			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH July 31, 1970 7 A. M.			
FULL NAME OF HOSPITAL OR INSTITUTION The Gould Convalesarium		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-24-93	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Milliner		10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. Warehime				14. MOTHER'S MAIDEN NAME Olevia Myers			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 216-03-9553A		17. INFORMANT Willard Warehime		ADDRESS 627 S. Streeper St., Baltimore, Md.	
18. 412.21 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive C-V disease				15 yrs			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic C-V disease				due to, or as a consequence of:			
				and Chr Brain Syndrome			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Toxic enteritis				30 hrs			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov 2 19 69 to July 31 19 70 that (I) (we) last saw the deceased alive on July 30 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE H.V. Harbold M.D.				23B. DATE SIGNED July 31, 1970			
23C. PHYSICIAN'S NAME (Type) H.V. HARBOLD M.D.				23D. ADDRESS 4706 Harford Road Baltimore Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-3-70		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Talley, M.D.		25C. FUNERAL DIRECTOR Nicholas T. Matthews		ADDRESS 3021 Eastern Ave., Baltimore, Md.	



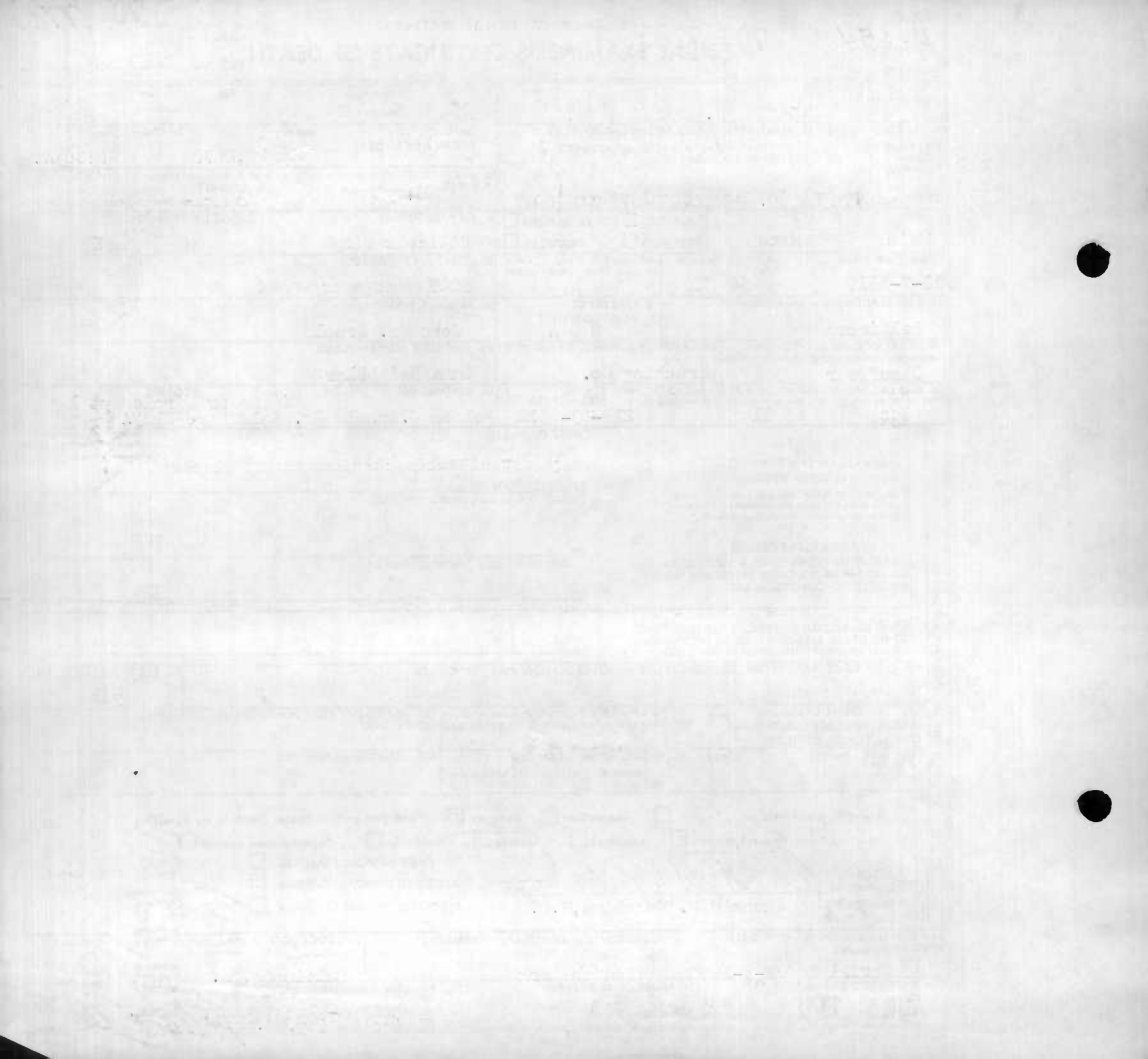
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 70 7724	
<p>M-265</p> <p>70 7724</p> <p>CERTIFICATE OF DEATH</p>		<p>BIRTH NO. 70 7724</p>					
<p>1. NAME OF DECEASED</p> <p>Type or Print <u>John Maurice McCormick</u></p>				<p>2. DATE AND HOUR OF DEATH</p> <p><u>July 30, 1970 12:55 P. M.</u></p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>90 Goulds Nursing Home</u></p>				<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER <u>5401 Mc Cormick Ave.</u></p>			
<p>5. SEX <u>Male</u></p>		<p>6. RACE <u>White</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>Jan. 19, 1894</u></p>	
<p>9. AGE (In years lost birthday) <u>76</u></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><u>Roofer</u></p>		<p>11. BIRTHPLACE (State or foreign country)</p> <p><u>Baltimore</u></p>		<p>12. CITIZEN OF WHAT COUNTRY</p> <p><u>U.S.A.</u></p>	
<p>13. FATHER'S NAME</p> <p><u>Charles J. McCormick</u></p>				<p>14. MOTHER'S MAIDEN NAME</p> <p><u>Ella J. Lambright</u></p>			
<p>15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><u>No</u></p>				<p>16. SOCIAL SECURITY NO.</p> <p><u>212-12-9487</u></p>		<p>17. INFORMANT</p> <p><u>Mrs. Ruth McCormick</u></p>	
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>				<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>20 yrs</u></p>			
<p>19A. DATE OF OPERATION <u>0</u></p>				<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p>				<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>				<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 14, 1968</u> to <u>July 30, 1970</u> that (I) (was) last saw the deceased alive on <u>July 30, 1970</u> and that (in my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (not) view the body after death.</p>							
<p>23A. SIGNATURE</p> <p><u>H. V. Harbold M.D.</u></p>				<p>23B. DATE SIGNED</p> <p><u>July 30, 1970</u></p>		<p>23C. PHYSICIAN'S NAME (Type)</p> <p><u>H. V. HARBOLD M.D.</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p><u>Burial</u></p>				<p>24B. DATE</p> <p><u>Aug. 3, 70</u></p>		<p>24C. NAME of CEMETERY or CREMATORY</p> <p><u>Gardens Of Faith</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p><u>AUG 5 1970</u></p>				<p>25B. NAME OF REGISTRAR</p> <p><u>Robert E. Tabor, M.D.</u></p>		<p>25C. FUNERAL DIRECTOR</p> <p><u>Funeral Home</u></p>	
<p>25D. LOCATION (City, town, or county)</p> <p><u>Baltimore</u></p>				<p>25E. ADDRESS</p> <p><u>7403 Belair Rd.</u></p>		<p>25F. STATE</p> <p><u>Md.</u></p>	



BALTIMORE CITY HEALTH DEPARTMENT				70 7725			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. _____			
BIRTH NO. _____				1. NAME OF DECEASED (Type or Print)			
NELSON J. ARNOLD, SR.				2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD Month Day Year Hour			
SOUTH BALTO. GENERAL HOSPITAL (DOA)				July 29, 1970 8:30 A.M.			
6. SEX		7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Ellicott City	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
11-2-1919		50		Baltimore		U S A	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
Chauffeur		Trucking Co.		Emma Reightler			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT			
Yes WW 11		219-03-6312		Nelson J. Arnold Jr. Baltimore 21234			
19. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Arteriosclerotic cardiovascular disease			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)			
2				yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED			
EXAMINER'S NAME (Type)		Ronald N. Kornblum, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		7/29/70	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-3-1970		Loudon Park		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			
AUG 5 1970		Robert E. Farber, M.D.		Higinbotham-Slack Funeral Home Ellicott City, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 7726		REG. NO.	
W-123 70 7726				BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <u>MRS. MARIE E. Webster</u>				2. DATE AND HOUR OF DEATH <u>8-2-70</u> <u>11:30 a.m.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Harbor View Ncc</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>603</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Harbor View Ncc</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>5/24/31/1902</u>		9. AGE (In years last birthday) <u>68</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>276-07-6486</u>		17. INFORMANT <u>Mr. Frederick S. Weakley, Jr. 5914</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>412.217250.9</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Pulmonary Edema</u> (B) <u>HASCO D; left hemiplegia</u> (C) <u>15 years</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8/2/70</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetic Mellitus, controlled.</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 18</u> 19 <u>69</u> to <u>Aug 2</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>8/2/70</u> 19 <u>11:35 AM</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Adoniam B. Paulino</u>				23B. DATE SIGNED <u>Aug 2, 1970</u>			
23C. PHYSICIAN'S NAME (Type) <u>Adoniam B. Paulino</u>				23D. ADDRESS <u>Harbor View Nursing Home Bldg. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/5/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 5 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Barber, M.D.</u>		25C. FUNERAL DIRECTOR <u>John A. Moran, Inc.</u>		ADDRESS <u>3000 E. Baltimore St.</u>	

FUNERAL DIRECTOR: IMPORTANT

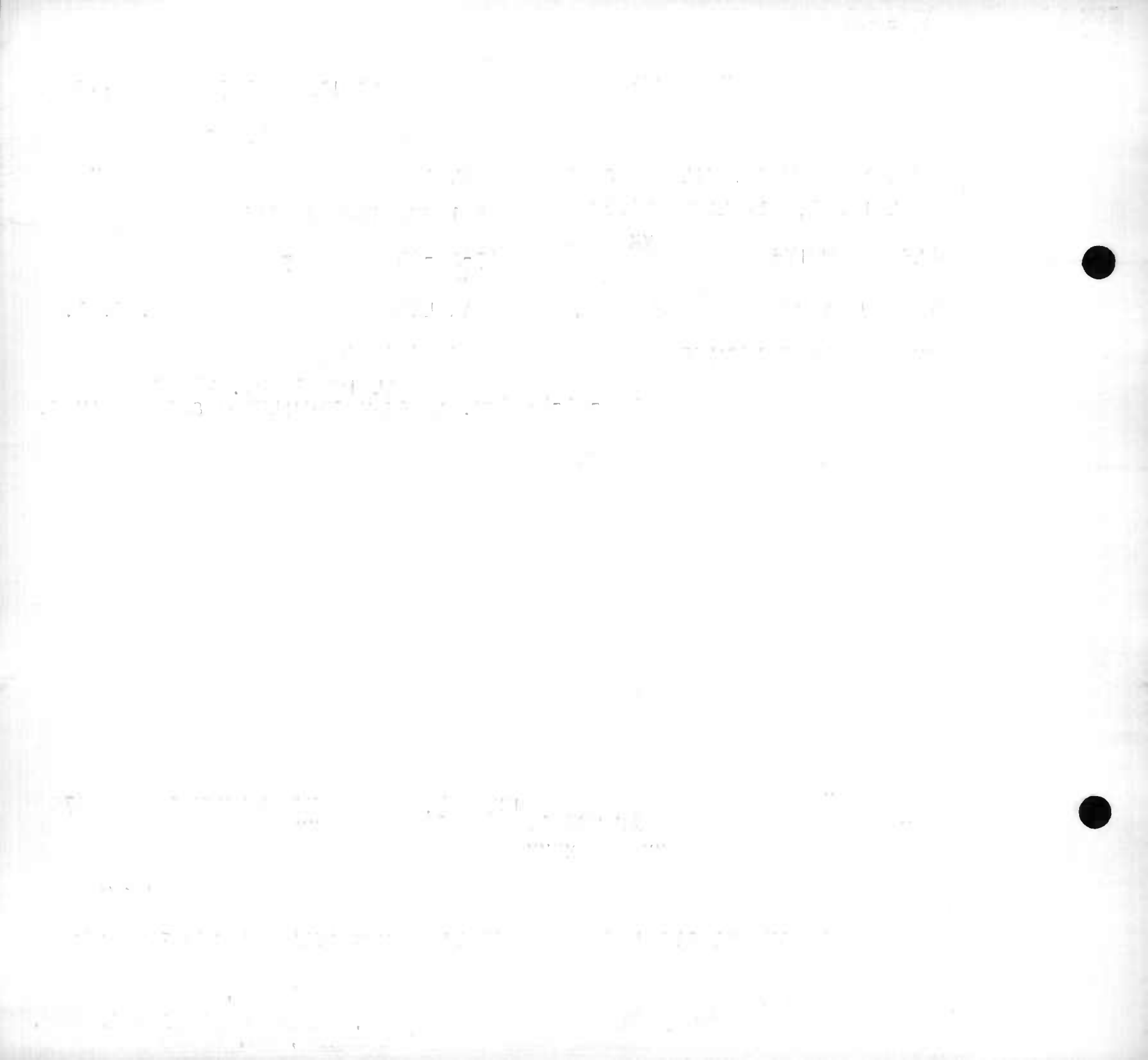
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7727	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) M. William Deford		2. DATE AND HOUR OF DEATH 8-3-70 11:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Bolton Hill Nursing & Convalescent Center		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 401 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 113 N. Paca Street			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-10-1912	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Corp		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas DeFord			14. MOTHER'S MAIDEN NAME Barbara Hunt		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes 1934-'37		16. SOCIAL SECURITY NO. 218-09-5811		17. INFORMANT ADDRESS Mrs. Catherine C. Bauer 3104 Liberty Pkwy.	
1B. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12/89	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/19 1970 to 8/3 1970 that (I) (we) last saw the deceased alive on 8/3 1970 and that in (my) (our) opinion death occurred on the date 8/3 1970 and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE al m...				23B. DATE SIGNED 8/4/70	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT MD		23D. ADDRESS 2 E Read St Balt MD 21202			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/6/70		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Jarboe M.D.		25C. FUNERAL DIRECTOR ADDRESS John A. Moran, Inc. 3000 E. Baltimore St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

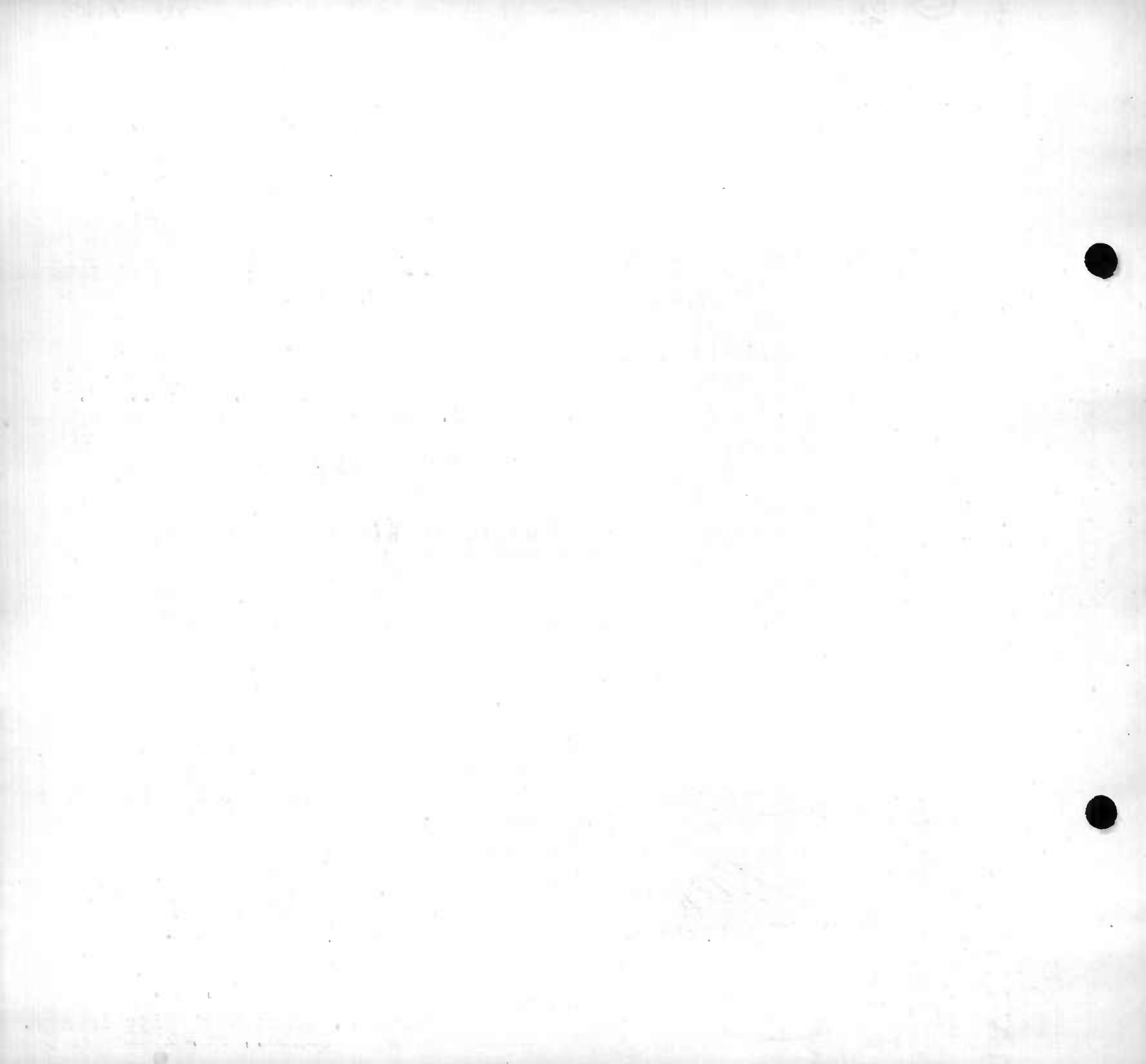
W-300 70 7728		BALTIMORE CITY HEALTH DEPARTMENT		70 7728	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) WHITE, AVERY HENRY		2. DATE AND HOUR OF DEATH AUGUST 1, 1970 3:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSP. WILKENS & CATON BALTIMORE, MARYLAND 21229		A. STATE MARYLAND B. COUNTY AA 21225 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 101 TUNGSTON STREET			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07-20-00	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WINDOW WASHER		10B. KIND OF BUSINESS OR INDUSTRY Glen Burnie Window Cleaning Co.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME AVERY THADDEUS WHITE			
14. MOTHER'S MAIDEN NAME ROSE (RENNER)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 220-01-4995		17. INFORMANT BALTIMORE, MD. 21229 ADDRESS ST. AGNES HOSP; WILKENS & CATON AVES.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebrovascular Accident Arteriosclerotic Heart Dis.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JULY 24, 1970 to AUGUST 1, 1970 that (X) (we) last saw the deceased alive on AUGUST 1, 1970 and that (X) (our) applan death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE Donato Vargas Jr		23B. DATE SIGNED 08/01/70		23C. PHYSICIAN'S NAME (Type) DONATO VARGAS JR MD	
23D. ADDRESS ST AGNES HOSPITAL BALTIMORE MD 21229		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 8/4/70		24C. NAME OF CEMETERY OR CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR George J. Gonca 4001 Ritchie Hwy. Baltimore, Md. 21225	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-654		70 7729		BALTIMORE CITY HEALTH DEPARTMENT		70 7729	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) PAUL KORNILOOK				2. DATE AND HOUR OF DEATH July 31, 1970 8:20 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital				4. USUAL RESIDENCE (When deceased lived, if institution; residence before admission) A. STATE MARYLAND. - AA 5200 C. CITY OR TOWN BALTIMORE. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 415 CRESSWELL Road.			
5. SEX M.	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/4/86	9. AGE (In years lost birthday) 84	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel.		11. BIRTHPLACE (State or foreign country) RUSSIA.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ? KORNILOOK.				14. MOTHER'S MAIDEN NAME —			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS 417 Creswell Rd. Balto., Md. Mr. Christopher Miller 21225		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. 451.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EMBOLISM. (B) THROMBO PHLEBITIS (both legs) (C) —					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). PULMONARY EDEMA, CHF.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1970 to July 31, 1970, that (B) (we) last saw the deceased alive on July 31, 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (B) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature] DEGREE				23B. DATE SIGNED July 31, 70			
23C. PHYSICIAN'S NAME (Type) ESPINOZA, M.D. DEGREE				23D. ADDRESS 3001 S. Hanover St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8 3 70		24C. NAME OF CEMETERY or CREMATORY Glen Haven		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hgy. Balto., Md. 21225		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 7730</u>	
BIRTH NO. <u>H-634 70 7730</u>					
1. NAME OF DECEASED (Type or Print) <u>Carl R. Hartleb</u>		2. DATE AND HOUR OF DEATH <u>8-1-70</u> <u>8:15 p. m.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bon Secours Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>637 Orpington Road</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01/18/91</u>	9. AGE (In years last birthday) <u>79 yrs</u>	10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Piano Tuner</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Hartleb, Bernard</u>		14. MOTHER'S MAIDEN NAME <u>Dora Barts</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-09-3094</u>		17. INFORMANT <u>Mrs. Bettie Hughes, 6310 Fair Oaks Ave. 21214</u>	
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) <u>Chronic congestive heart failure</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>year</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF:		(C) <u>year</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Thrombotic renal artery</u>		<u>days</u>			
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (the) (this hospital) attended the deceased from <u>July 23</u> 19 <u>70</u> to <u>Aug 1</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>Aug 1</u> 19 <u>70</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lilia Lofranco</u>		23B. DATE SIGNED <u>8-1-70</u>		23C. PHYSICIAN'S NAME (Type) <u>Lilia Lofranco M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-5-1970</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 5 1970</u>		25B. NAME OF REGISTRAR <u>Robert J. ...</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <u>70 7731</u>	
BIRTH NO. <u>B-450</u>		70 7731		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CHARLES A. BLANEY			2. DATE AND HOUR OF DEATH August 2, 1970 9 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 916 Calwell Road Baltimore, Maryland			A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 916 Calwell Road		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-29-1902	9. AGE (in years lost birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tool Salesman			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Charles G. Blaney		
14. MOTHER'S MAIDEN NAME Emma Harman			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 220-01-4422			17. INFORMANT ADDRESS Mrs. Laura Blaney, 8507 Willow Oak Rd. 21234		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Coronary thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Obesity II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Spinal Cord disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes ?		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (the hospital) attended the deceased from 1960 to death 19____ that (1) (the hospital) last saw the deceased alive on April 1 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Crawford N. Kirkpatrick, Jr.				23B. DATE SIGNED 8-3-70	
23C. PHYSICIAN'S NAME (Type) Crawford N. Kirkpatrick, Jr.				23D. ADDRESS 6 E. Eager Street, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-6-1970		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			

$$x = \sqrt{x} \cdot \cos(\theta)$$

$$y = \sqrt{y} \cdot \sin(\theta)$$

$$x = \sqrt{x} \cdot \cos(\theta)$$

$$y = \sqrt{y} \cdot \sin(\theta)$$

$$x = \sqrt{x} \cdot \cos(\theta)$$

$$y = \sqrt{y} \cdot \sin(\theta)$$

$$x = \sqrt{x} \cdot \cos(\theta)$$

$$y = \sqrt{y} \cdot \sin(\theta)$$

$$x = \sqrt{x} \cdot \cos(\theta)$$

$$y = \sqrt{y} \cdot \sin(\theta)$$

$$x = \sqrt{x} \cdot \cos(\theta)$$

$$y = \sqrt{y} \cdot \sin(\theta)$$

$$x = \sqrt{x} \cdot \cos(\theta)$$

$$y = \sqrt{y} \cdot \sin(\theta)$$

$$x = \sqrt{x} \cdot \cos(\theta)$$

$$y = \sqrt{y} \cdot \sin(\theta)$$

$$x = \sqrt{x} \cdot \cos(\theta)$$

$$y = \sqrt{y} \cdot \sin(\theta)$$

$$x = \sqrt{x} \cdot \cos(\theta)$$

$$y = \sqrt{y} \cdot \sin(\theta)$$

$$x = \sqrt{x} \cdot \cos(\theta)$$

$$y = \sqrt{y} \cdot \sin(\theta)$$

$$x = \sqrt{x} \cdot \cos(\theta)$$

$$y = \sqrt{y} \cdot \sin(\theta)$$

$$x = \sqrt{x} \cdot \cos(\theta)$$

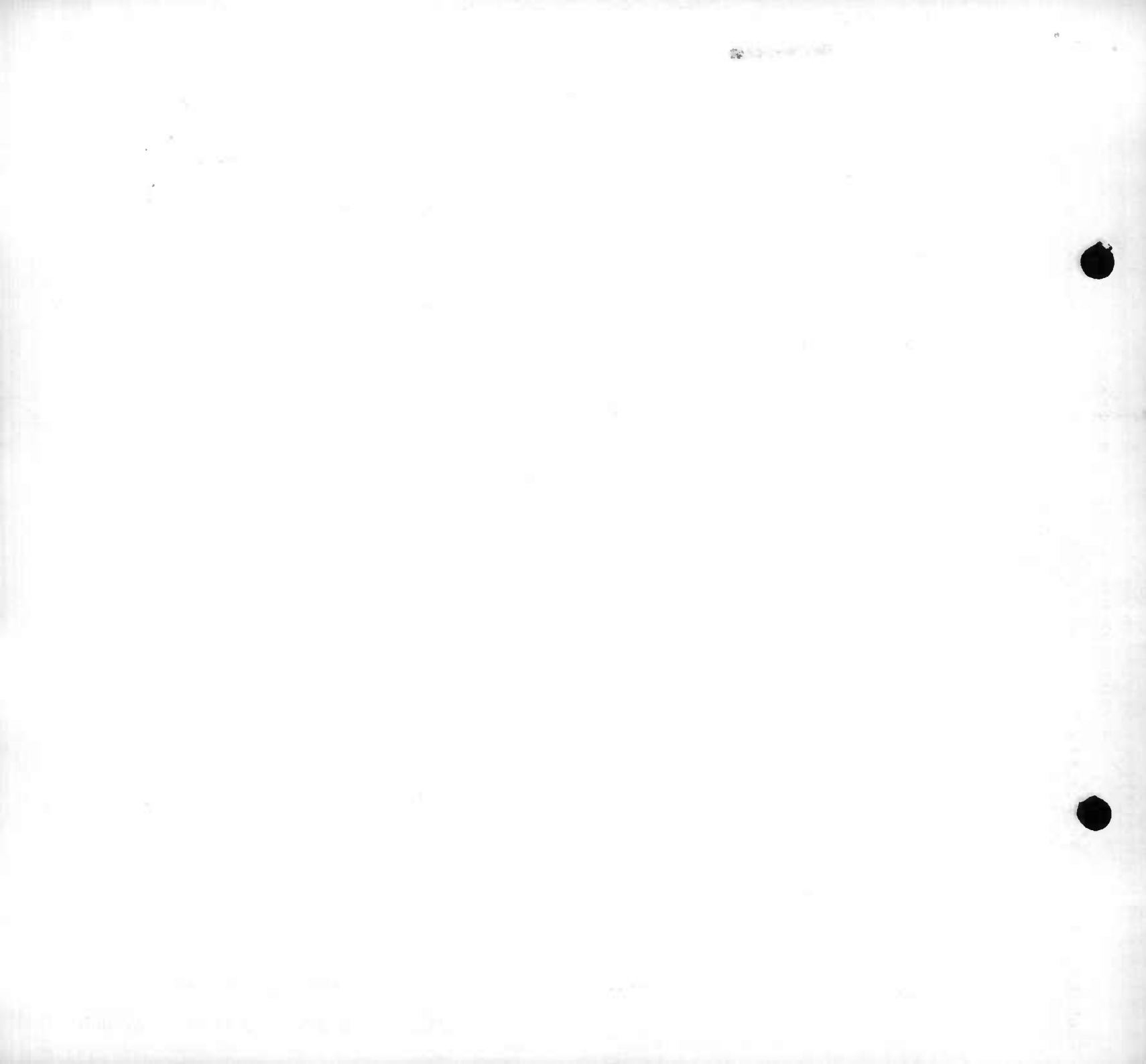
$$y = \sqrt{y} \cdot \sin(\theta)$$

$$x = \sqrt{x} \cdot \cos(\theta)$$

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.	
A-223 70 7732		BIRTH NO.		70 7732	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
AGOSTINI MRS EMMA D A			AUG 2ND 1970 8:45A M		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
35			C. CITY OR TOWN BALTIMORE		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 1106 STEELTON AVENUE		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-4-00	9. AGE (in years last birthday) 70	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE			10B. KIND OF BUSINESS OR INDUSTRY -		
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA			12. CITIZEN OF WHAT COUNTRY? AMERICAN		
13. FATHER'S NAME ANTHONY ZANDY			14. MOTHER'S MAIDEN NAME CAROLYN ZANDY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 217-54-3837		
17. INFORMANT			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). DIABETES MELLITUS			CAUSE OF DEATH (A) IMMEDIATE CAUSE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-23-1970 to 8-27-70 that (I) (we) last saw the deceased alive on 8-2-1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Finger			23B. DATE SIGNED 8/2/70		
23C. PHYSICIAN'S NAME (Type) FIR-24			23D. ADDRESS 40		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-5-70		24C. NAME of CEMETERY or CREMATORY Sacred Heart of Jesus	
24D. LOCATION (City, town, or county) Baltimore, Maryland		15 total			
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR WALTER DABROWSKI 1005 DUNDALK AVENUE	
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7733	
BIRTH NO. J-525 70 7733		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) James Johnson			2. DATE AND HOUR OF DEATH JULY 30, 1970 5:20 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 1506		
FULL NAME OF HOSPITAL OR INSTITUTION 44 LUTHERAN HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 1801 Chelsea		
5. SEX male	6. RACE american	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-21-1905	9. AGE (in years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hamstead, Md	
13. FATHER'S NAME Robert Johnson			14. MOTHER'S MAIDEN NAME Myrtle J. Jenkins		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes War # 2 217-16-5817			16. SOCIAL SECURITY NO. 217-16-5817		
17. INFORMANT Maggie Johnson			ADDRESS 1801 Chelsea Rd		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) 4-10-91			CAUSE OF DEATH (A) IMMEDIATE CAUSE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from JULY 30 , 19 70 to JULY 30 , 19 70 that we (we) lost saw the deceased alive on JULY 30 , 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) (did not) view the body after death.					
23A. SIGNATURE Christos Dibranos			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED JULY 30, 70
23C. PHYSICIAN'S NAME (Type) CHRISTOS DIBRANOS, M.D.			23D. ADDRESS 730 ASHBURTON STR., BALTO. MD. 21212		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-3-70	24C. NAME OF CEMETERY or CREMATORY Baltimore Nat. Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR William F. H.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7734

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS JACKSON

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
HOSPITAL ADDRESS OR LOCATION)

34 Bon Secours Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

8

2

1970

1:40 A

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md. B. COUNTY 1901

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Sept-6-55

10. AGE (In years
last birthday)

15

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

229 N. Calhoun St.

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF

WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Adessa Graham

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give waf or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

Adessa Graham

ADDRESS

229 N. Calhoun St.

19.

E 968 X

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Craneo-cerebral injuries

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes (head only)

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

229 W. Calhoun St. 1901

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

8-2-70 app. 12:15 A

22E. INJURY OCCURRED.

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subj. beaten on head with bat.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-2-70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-6-70

24C. NAME OF CEMETERY or CREMATORY

Mt Calvary

24D. LOCATION (City, town, or county) (State)

Brooklyn Md

25A. DATE REC'D BY HEALTH DEPT.

AUG 5 1970

25B. NAME OF REGISTRAR

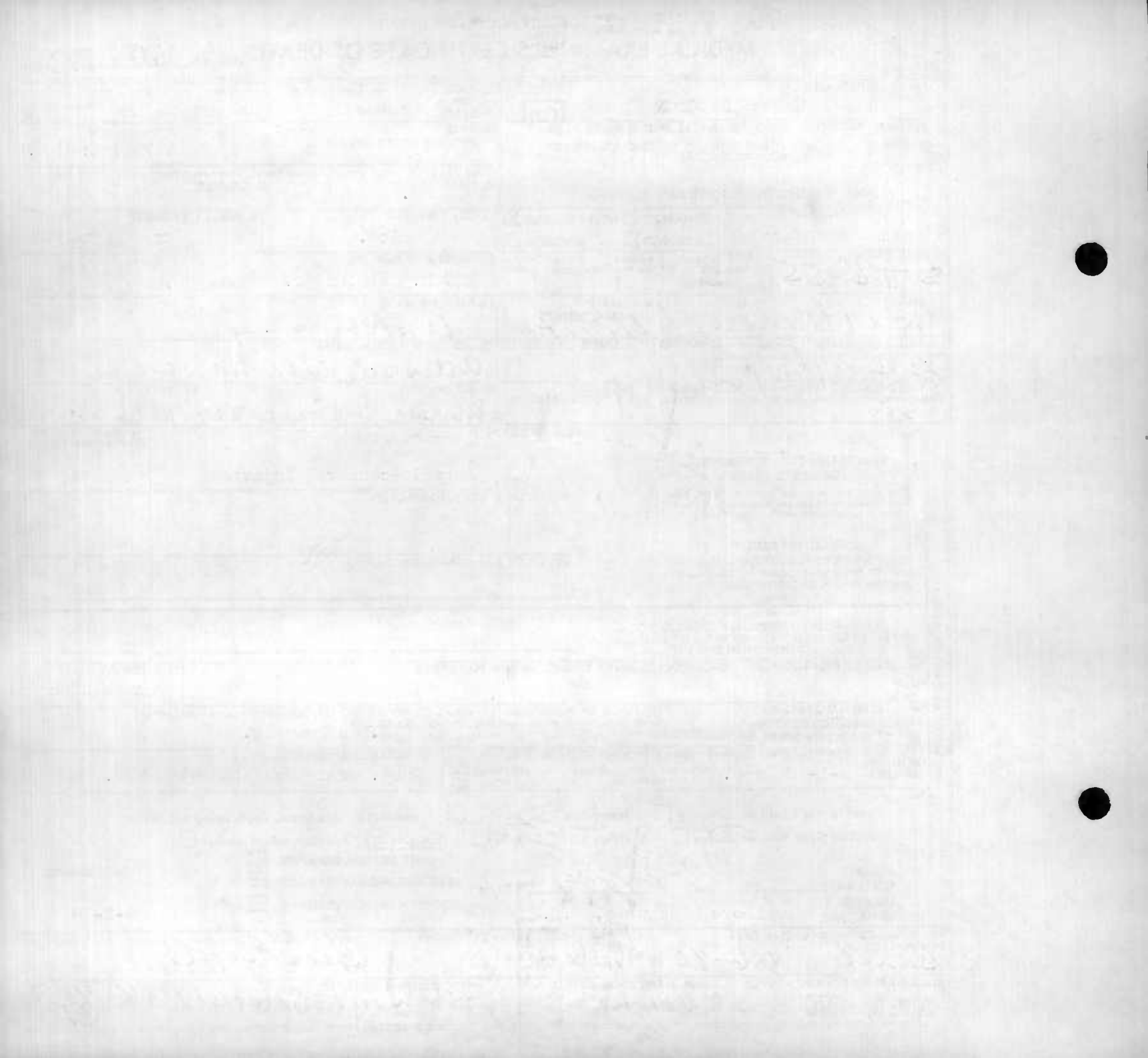
Isidore E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Stilson & Wilson

ADDRESS

1913 W. Balto, ST.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-613 70 7735		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7735	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) EVERETT L. CRAFTON		2. DATE AND HOUR OF DEATH July 29, 1970 9:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1602		5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION Univ. of Md. Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 612 N. Carey St.	
6. SEX M	7. RACE N	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 2-2-08	10. AGE (in years last birthday) 62	11. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Mill		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME Lucy Crafton		14. MOTHER'S MAIDEN NAME Emma Williams	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes War 2		16. SOCIAL SECURITY NO. 213-07-6904		17. INFORMANT HOSPITAL Record	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 199.01-5-71.0		CAUSE OF DEATH Carcinomatosis ? etiol.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. alcoholic cirrhosis, Diabetes mellitus years		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20A. AUTOPSY? (Yes or No) No	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 5, 1970 to July 29, 1970 that (I) (we) last saw the deceased alive on July 29, 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick Pearson, MD		DEGREE		23B. DATE SIGNED July 29, 1970	
23C. PHYSICIAN'S NAME (Type) FREDERICK PEARSON, MD		DEGREE		23D. ADDRESS Univ. of Md. Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-4-70		24C. NAME OF CEMETERY or CREMATORY London Park Nat.	
24D. LOCATION (City, town, or county) Baltimore Md		(State) Md		25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970	
25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR William Wilson		ADDRESS Balto, Md	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7736	
M-245 70 7736		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <u>KEVIN R. McCallum</u>		2. DATE AND HOUR OF DEATH <u>August 3 - 70</u> <u>4:15</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Md. Hospital</u>		A. STATE <u>MD</u>		B. COUNTY <u>2102</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <u>1248 Washington Blvd.</u>		<u>21230</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-17-60</u>	9. AGE (in years last birthday) <u>10 year</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Kenneth McCallum</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Grimes</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>Hospital chart.</u>	
18. <u>1939 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ASTROCYTOMA GII		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>Jul-10-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Partial resection of a Tumor</u>		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-3-1970</u> to <u>August-3-1970</u> that (I) (we) last saw the deceased alive on <u>August 3-19-70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Onsorez</u> MD.		23B. DATE SIGNED <u>8/3/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Jorge R. Onsorez MD.</u>	
23D. ADDRESS <u>University Md. Hospital.</u>		23E. FUNERAL DIRECTOR <u>John J. Cowan & Son Inc.</u>		23F. ADDRESS <u>701 N. ...</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/6/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>	
24D. LOCATION <u>Baltimore Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>AUG 5 1970</u>		24F. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

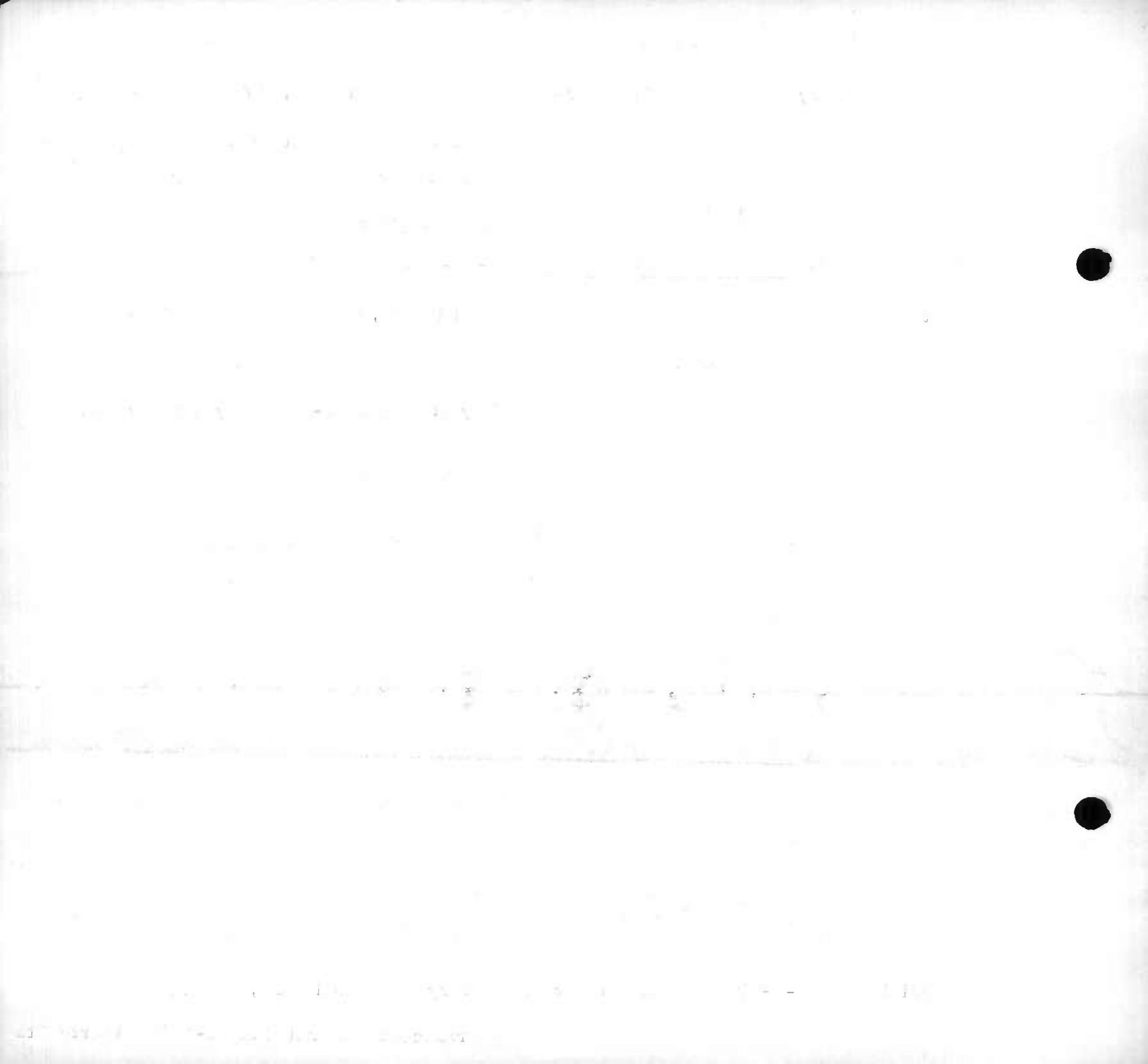
F-563 70 7737		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7737	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CARL F. EMMAART		2. DATE AND HOUR OF DEATH 8. 2. 70 6.45 a.m. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 311 Edsdate Rd #29			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-29-93	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CALEB F. Emmaart		14. MOTHER'S MAIDEN NAME CLARA TAMANUS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-12-8354		17. INFORMANT D. MICHEL SADE Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE PULMONARY EDEMA		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MS, ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 minutes	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II AMPUTATION OF LOWER LIMBS					
19A. DATE OF OPERATION 7-25-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene of both legs		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> Inotify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 7. 23-68 1968 to 8. 2 1970 that (I) (we) last saw the deceased alive on 8. 2 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE MICHEL SADE M.D.		23B. DATE SIGNED P. 2. 1970		23C. PHYSICIAN'S NAME (Type) MICHEL SADE, M.D.	
23D. ADDRESS B. C. H. 4940 Eastern Avenue, Baltimore, Maryland 21224		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-5-70	
24C. NAME of CEMETERY or CREMATORY MT Olive Cemetery		24D. LOCATION Randallstown, Md		25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970	
25B. NAME OF REGISTRAR Robert E. Tabor, R.D.		25C. FUNERAL DIRECTOR		25D. ADDRESS Armacost Funeral Chapel-4600 Liberty Hts	



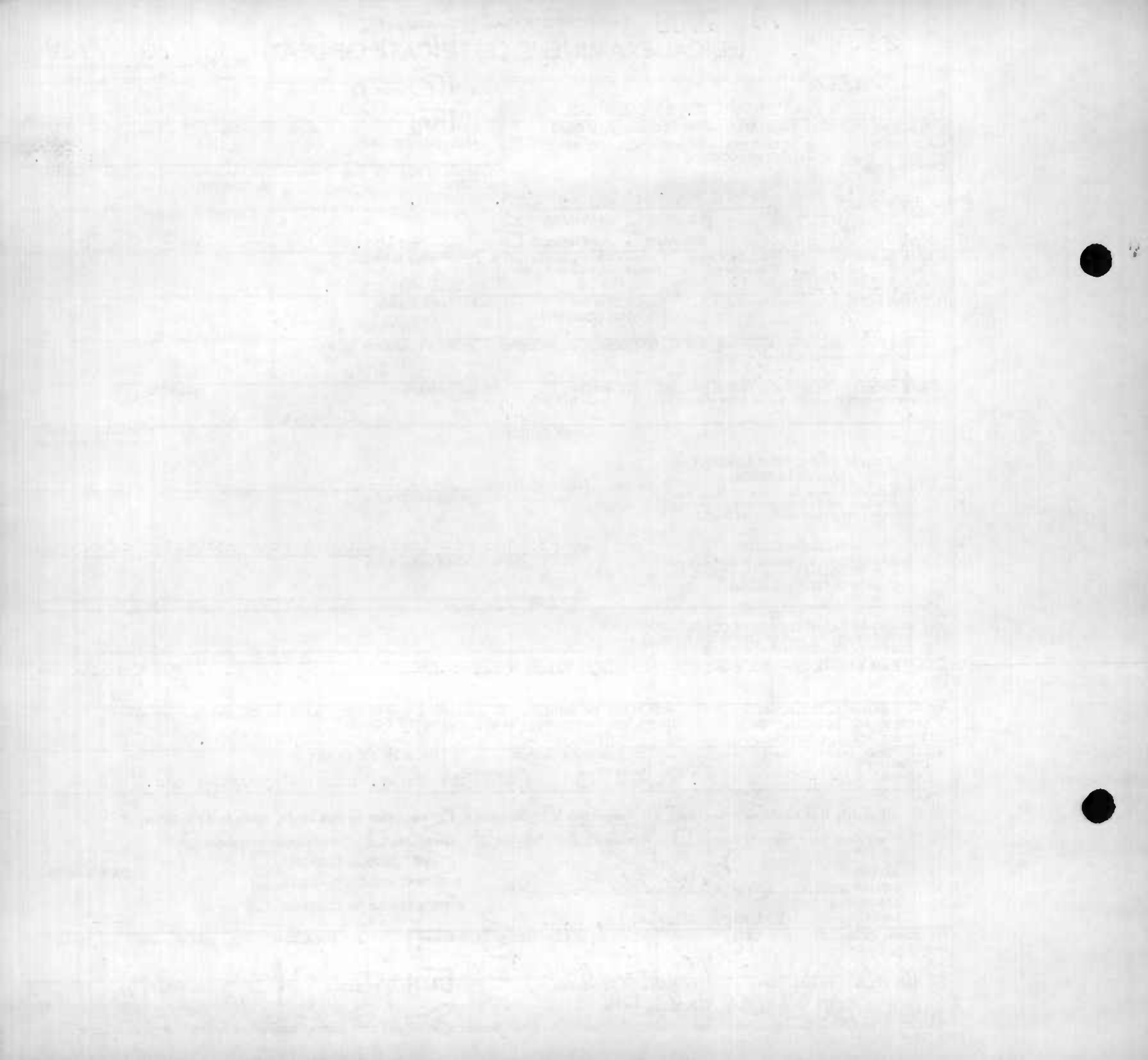
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7738	
C-516 70 7738				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mary A Chambers		July 31, 1970 4:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL			A. STATE B. COUNTY Maryland Baltimore		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3204 Hayward Avenue		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
Female	White		9-30-1900	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
At Home			Baltimore, Md		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Burns			Miller		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO					Phyllis Danaker-3204 Hayward Avenue
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Myocardial Infarction</i>		
ANTECEDENT CAUSES			(B) <i>Coronary atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: <i>arteriosclerotic cardiovascular disease</i>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) <i>& Chronic Myocarditis</i>		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>July 13 1956</i> to <i>July 31 1970</i> that (I) was last saw the deceased alive on <i>July 20 1970</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death. <i>deceased & medical examiner</i>					
23A. SIGNATURE <i>Harry L. Knipp, MD.</i>				23B. DATE SIGNED <i>8-3-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>HARRY L. KNIPP, MD.</i>				23D. ADDRESS <i>4116 Edmondson Ave. Balt. Md. 21227</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8-4-1970		Loudon Park Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 5 1970		Robert E. Taylor, R.D.		Armocost Funeral Chapel-4600 Liberty Hts	



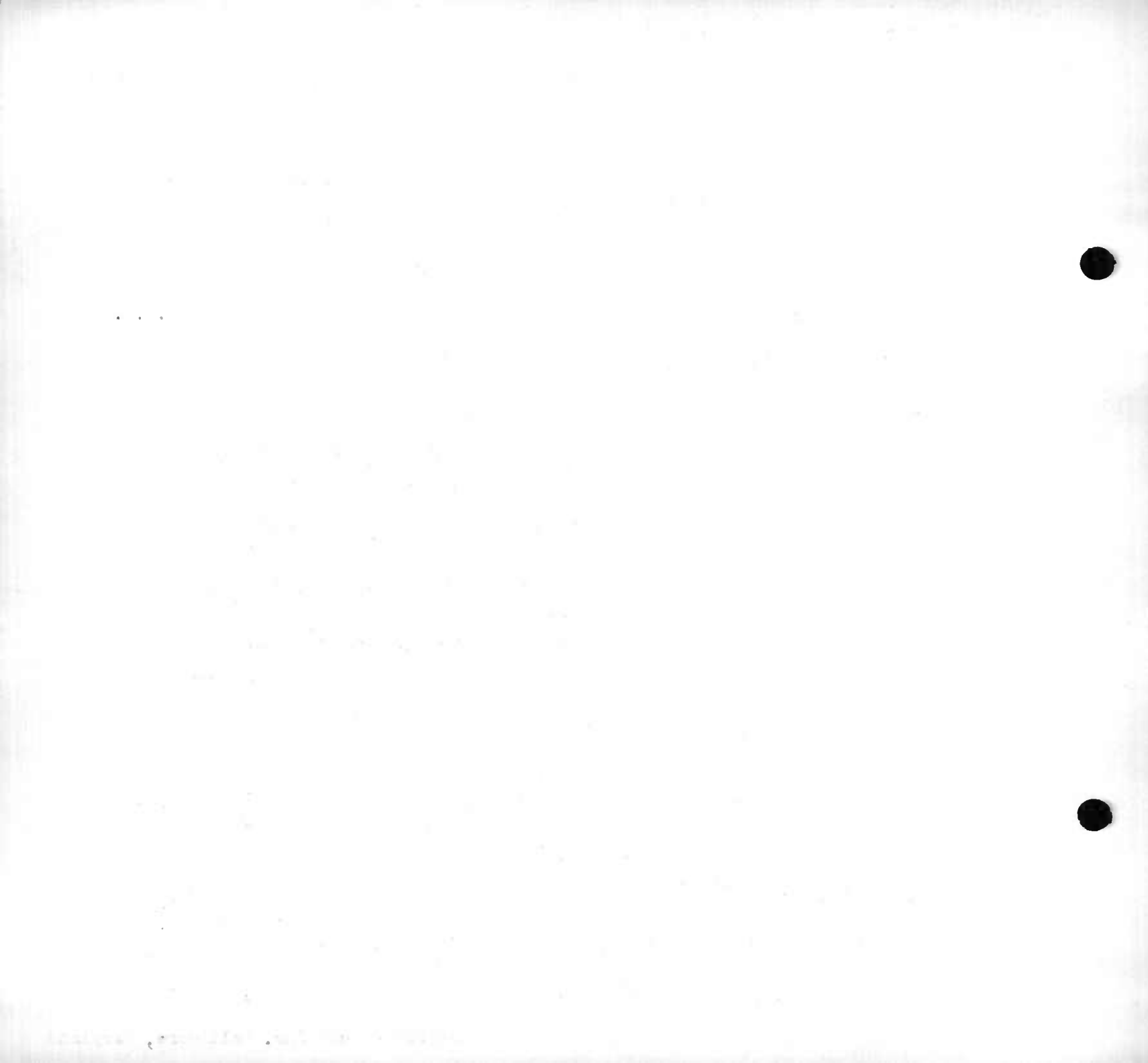
B-655		70 7739		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 7739	
1. NAME OF DECEASED (Type or Print) THOMAS C. BIRMINGHAM									
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Daniel's Junkyard 2244 Washington Blvd									
2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 8 1 1970 4:15 P.M.									
3. DATE PRONOUNCED DEAD Month Day Year Hour 8 1 1970 4:15 P.M.									
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. CITY OR TOWN Balto. C. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
6. SEX Male 7. RACE White 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
9. DATE OF BIRTH 6/12/1951 10. AGE (In years lost birthday) 19 11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME Thomas B. Birmingham									
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Art Craft 15. MOTHER'S MAIDEN NAME Mary Wilbur									
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no 17. SOCIAL SECURITY NO. 212-380721 18. INFORMANT Mr. Thomas Birmingham ADDRESS Above									
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE Asphyxia (B) propane gas inhalation to the exclusion of oxygen (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
20A. DATE OF OPERATION 8-1-70 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED no 21. AUTOPSY? (Yes or No) no									
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) junkyard 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 2244 Washington Blvd.									
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 8-1-70 ? m. 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 22F. HOW DID INJURY OCCUR? Subj. inhaled propane gas.									
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-2-70									
24A. BURIAL CREMATION, REMOVAL (Specify) Buried 24B. DATE 8/5/70 24C. NAME OF CEMETERY OR CREMATORY London Park Cem. 24D. LOCATION (City, town, or county) (State) Baltimore Md.									
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR John J. Cowan & Son Inc. ADDRESS 2311 Hall St.									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7740	
3-162 70 7740		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GEORGE O. SPOERKE		2. DATE AND HOUR OF DEATH 7/31/70 11:30P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) GOULD CONValesARIUM		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY 2734			
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4123 KINSWAY			
5. SEX M	6. RACE CAV	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 2 1887	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Oswald Spoerke		14. MOTHER'S MAIDEN NAME Anna ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Minna Kornick	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 41231 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Obstructive coronary artery disease		CAUSE OF DEATH Arteriosclerotic Heart Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: Emphysema + Ch Bronchitis (C) DUE TO, OR AS A CONSEQUENCE OF: Benign Prostatic Hypertrophy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 1 19 70 to July 31 19 70 that (I) (we) last saw the deceased alive on 7/31 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald W. Mintzer		23B. DATE SIGNED 7/31/70		23C. PHYSICIAN'S NAME (Type) DONALD W. MINTZER	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/4/70		24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. ADDRESS 3009 EVERGREEN AVE		24F. STATE MD	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR J. E. Jaber, M.D.		25C. FUNERAL DIRECTOR Leonard J Ruck Inc.	
				ADDRESS Baltimore, Maryland	



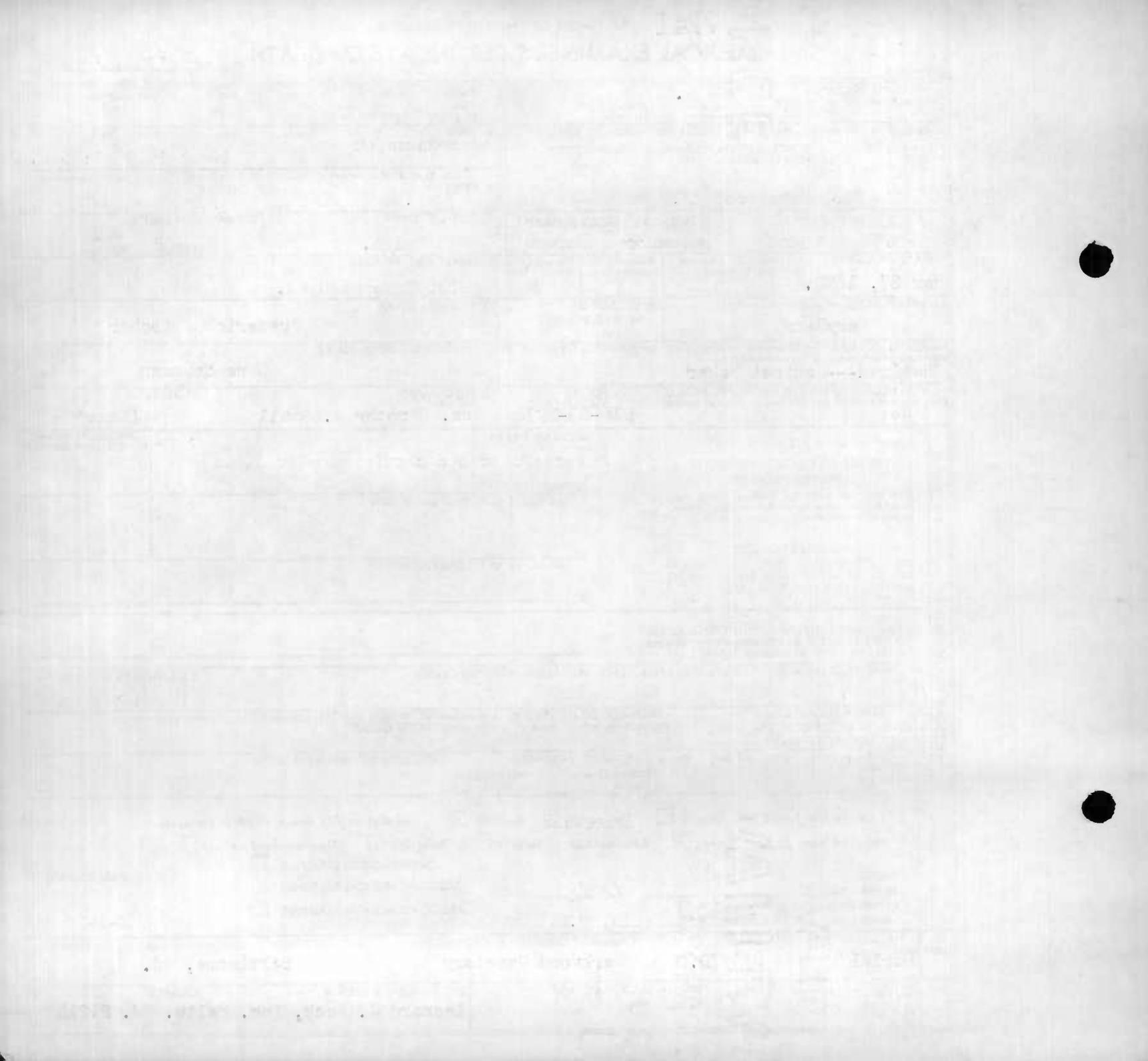
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 7741

BIRTH NO.

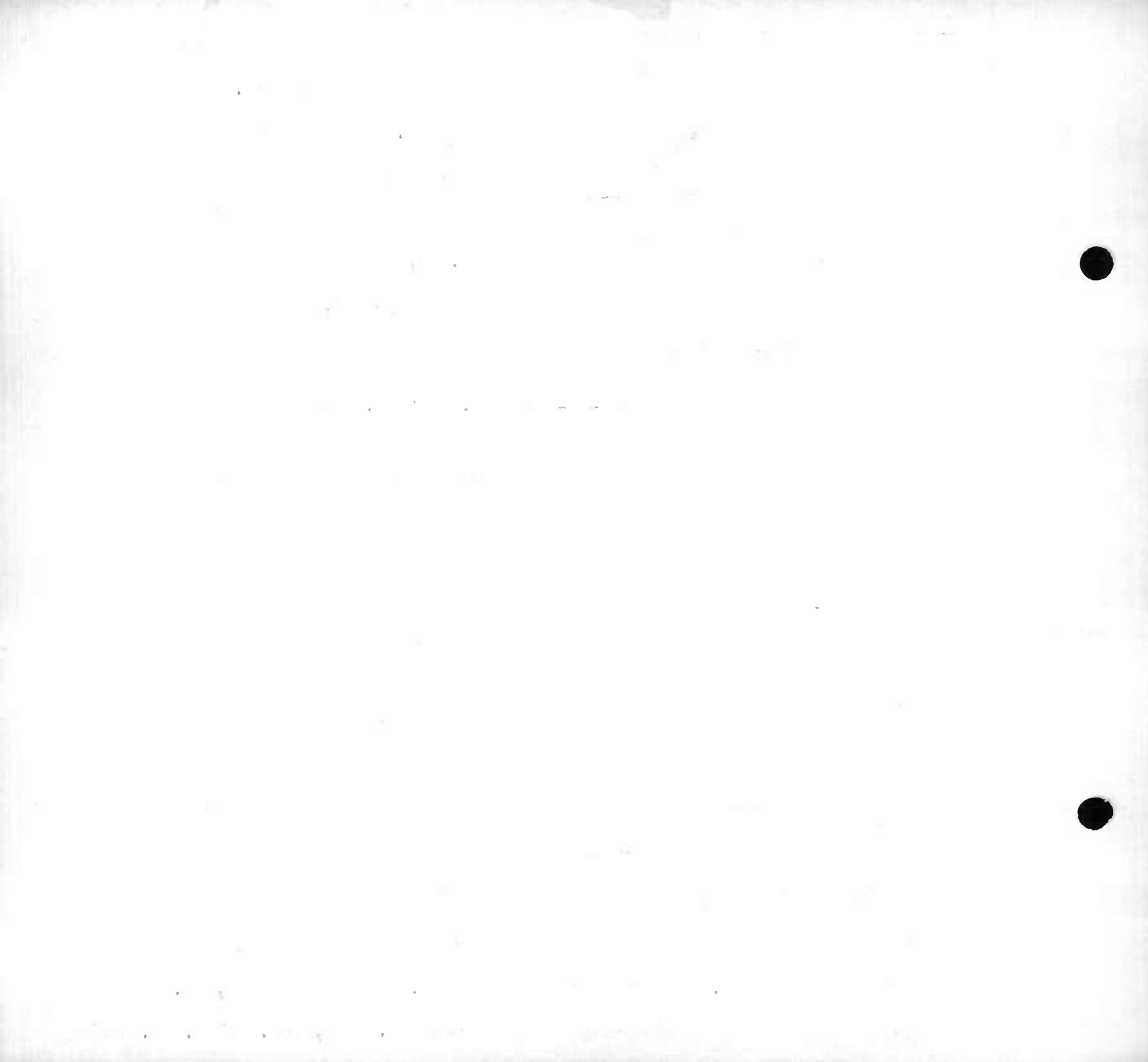
1. NAME OF DECEASED (Type or Print) G. FREDERICK DISCHER				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3333 Ravenwood Rd.				3. DATE PRONOUNCED DEAD Month Day Year Hour 8 1 1970 1:35 P.M.			
6. SEX Male				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH May 27, 1890.				10. AGE (in years last birthday) 80		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Frederick Discher			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired---Cabinet Maker				14B. KIND OF BUSINESS OR INDUSTRY			
15. MOTHER'S MAIDEN NAME Dora Bawmann				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
17. SOCIAL SECURITY NO. 216-03-5934				18. INFORMANT ADDRESS Mrs. Dorothy H. Small (Same)			
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) no							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 8-2-70							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8/5/70.			
24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT AUG 5 1970				25B. NAME OF REGISTRAR Robert E. Bailey, M.D.			
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

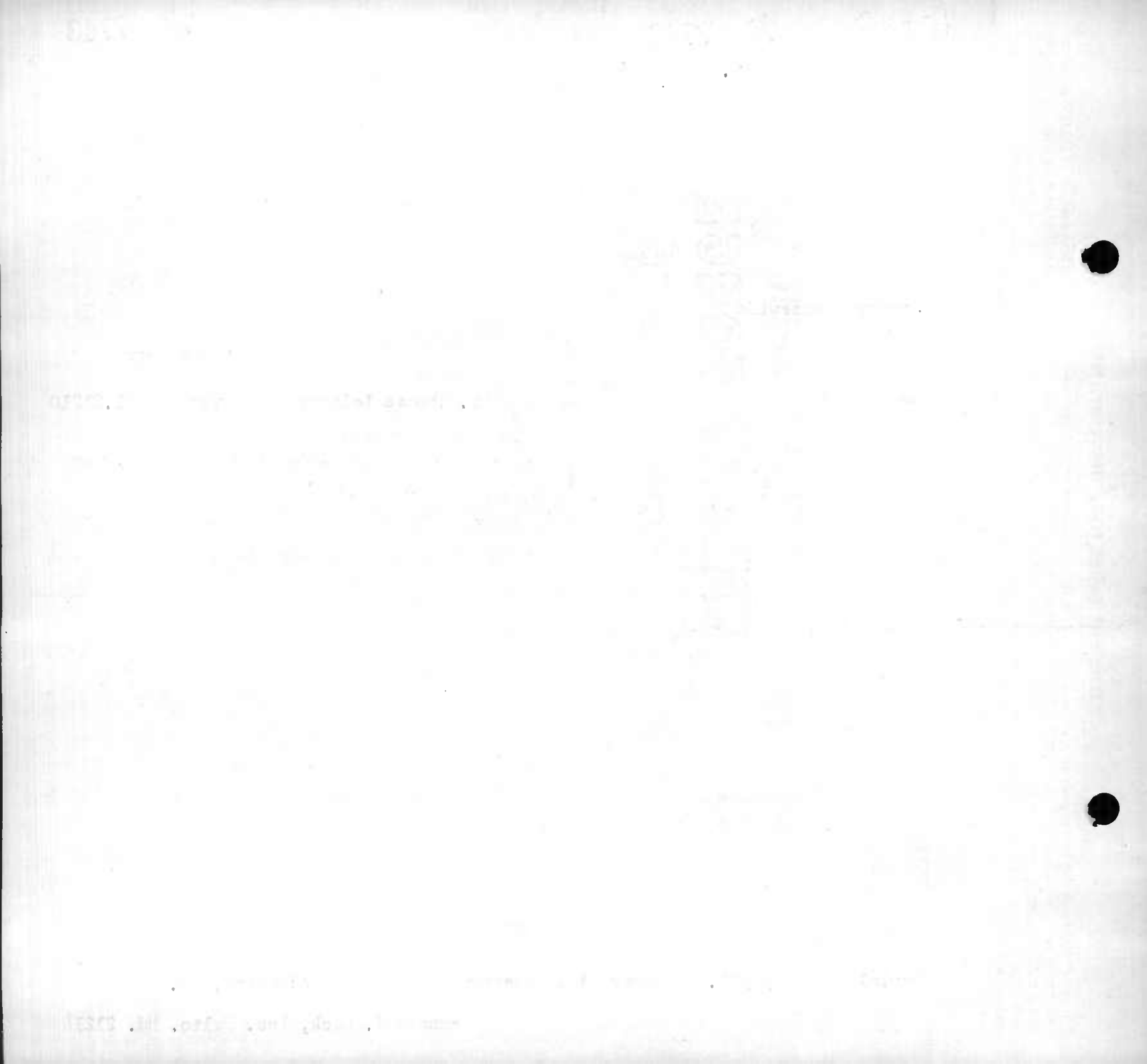
F-160 70 7742		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
Katherine MARY CATHERINE FIFER		July 31, 1970.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 99 Baltimore City Hospital--DOA		A. STATE Md.	
		B. COUNTY Baltimore	
5. SEX Female		6. RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1918	
9. AGE (in years last birthday) 52		10. CITIZEN OF WHAT COUNTRY? USA	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter Keister		14. MOTHER'S MAIDEN NAME Leona ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-14-6697	
17. INFORMANT Mr. Homer E. Fifer		ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH RHEUMATIC HEART DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 39 YEARS	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCTOBER 19 51 to MAY 12 19 70 that (I) (we) last saw the deceased alive on MAY 12 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Anthony A. Lewandowski M.D.		23B. DATE SIGNED 8-1-70	
23C. PHYSICIAN'S NAME (Type) ANTHONY A LEWANDOWSKI M.D.		23D. ADDRESS 11 E CHASE ST BALTIMORE MD 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/3/70.	
24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Com.		24D. LOCATION (City, town, or county) (State) Elkridge, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

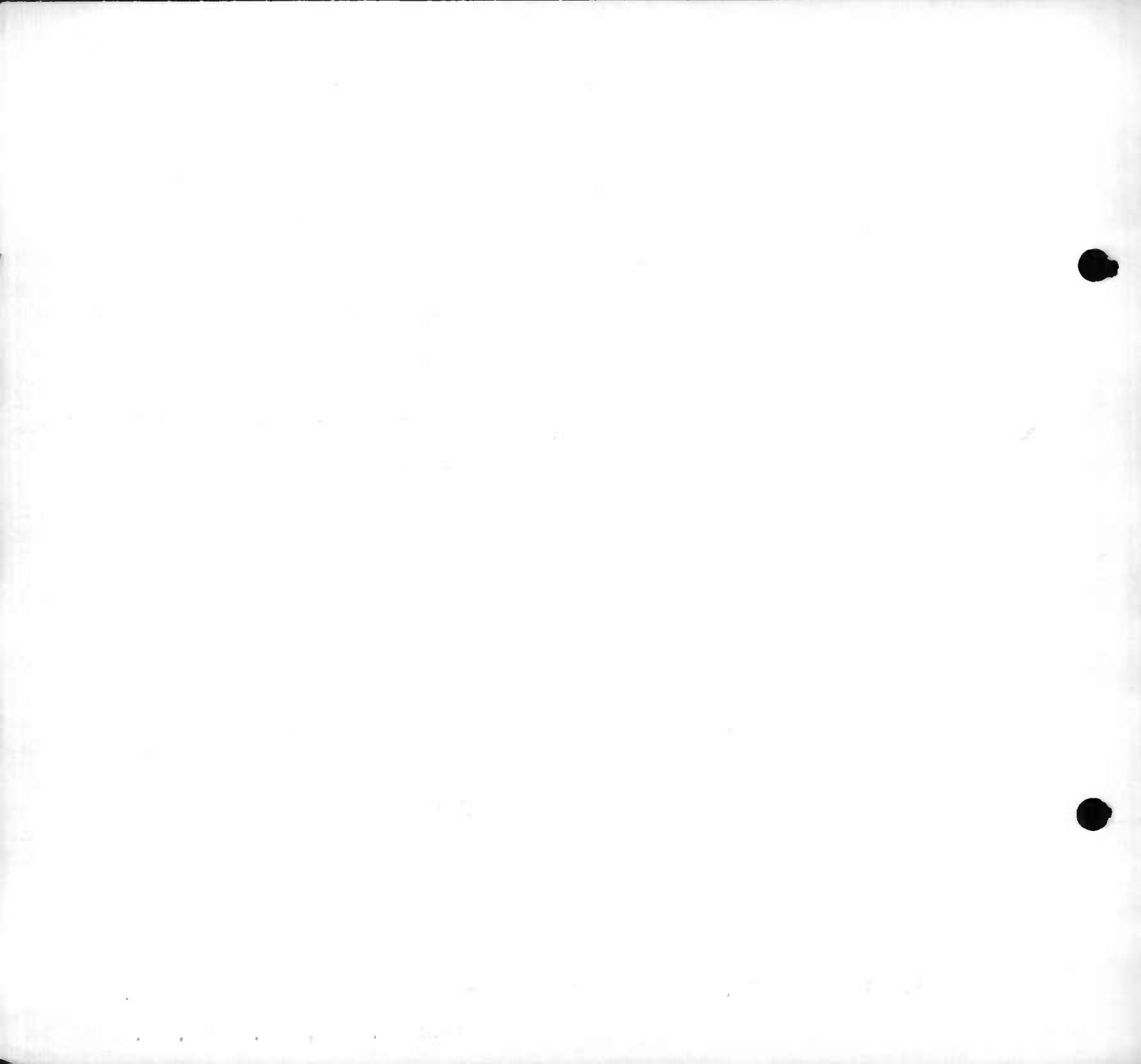
L-260 BIRTH NO. 70 7743		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 70 7743	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) HELEN E. LEIZEAR			2. DATE AND HOUR OF DEATH 7/31/70 2:07 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Balto. Md. B. COUNTY 2747 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2808 Pine wood Ave		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 9/18/98	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Not		11. BIRTHPLACE (State or foreign country) Baltimore Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas Johnson			14. MOTHER'S MAIDEN NAME Margaret May Chambers		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-22-4879	17. INFORMANT ADDRESS Mr. Thomas Leizear, 6000 Overlook Pl. 21210		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary edema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial infarct ASHD, & coronary thrombosis			CAUSE OF DEATH (A) DUE TO Failure of Lt. Vent. Auricle (B) DUE TO Myocardial Infarction (C) ASHD, & coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH 4 weeks
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/20 19 70 to 7/31 19 70 , that (I) (we) last saw the deceased alive on 7/31 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Paul Felipa				23B. DATE SIGNED 7/31/70	
23C. PHYSICIAN'S NAME (Type) PAUL FELIPA		23D. ADDRESS M.D. Maryland General Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/4/70.	24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

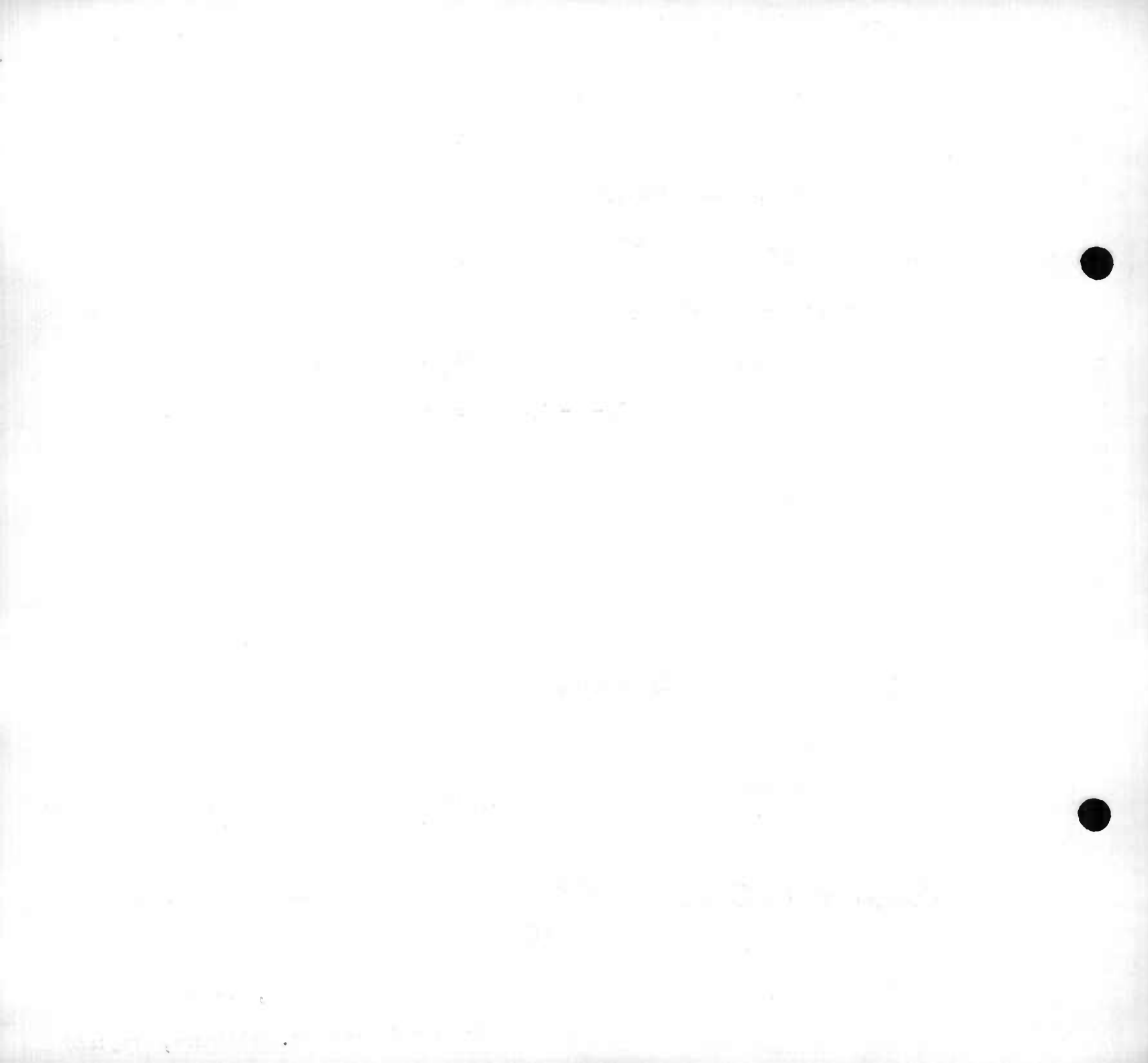
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7744</u>	
BIRTH NO. <u>D-120</u>		70 7744		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>EDWARD K. DAVIS</u>			2. DATE AND HOUR OF DEATH <u>8/1/70</u> <u>18:53</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME + HOSPITAL</u> <u>35</u>			5. CITY OR TOWN <u>BALTIMORE</u> <u>21206</u>		
6. RACE <u>W</u>			7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
7. SEX <u>M</u>			8. DATE OF BIRTH <u>9/17/88</u>		
9. MARIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. AGE (In years last birthday) <u>81</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>WELDER</u>		
11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>WALTER DAVIS</u>			14. MOTHER'S MAIDEN NAME <u>EMMA CRAWFORD</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>1904 → 1908</u>			16. SOCIAL SECURITY NO. <u>221-09-6148</u>		
17. INFORMANT <u>DAUGHTER (MRS. SHALLER)</u>			ADDRESS <u>7126 GREENWOOD AVE</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>4.10.01</u> ACUTE MYOCARDIAL INFARCT.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF:			<u>10 YRS.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>PROSTATIC HYPERTROPHY</u>			<u>5 YRS</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NO</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NO</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>NO</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>NO</u>	
22. I certify that (1) (this hospital) attended the deceased from <u>8/1/70</u> to <u>8/1/70</u> 19<u>70</u> that (1) (we) last saw the deceased alive on <u>8/1/70</u> 19<u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Patrick F. Dougherty, Jr., M.D.</u>			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/1/70</u>
23C. PHYSICIAN'S NAME (Type) <u>PATRICK F. DOUGHERTY, JR., M.D.</u>			23D. ADDRESS <u>CHURCH HOME + HOSPITAL</u>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/5/70.</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Wilmington, Delaware.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 5 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

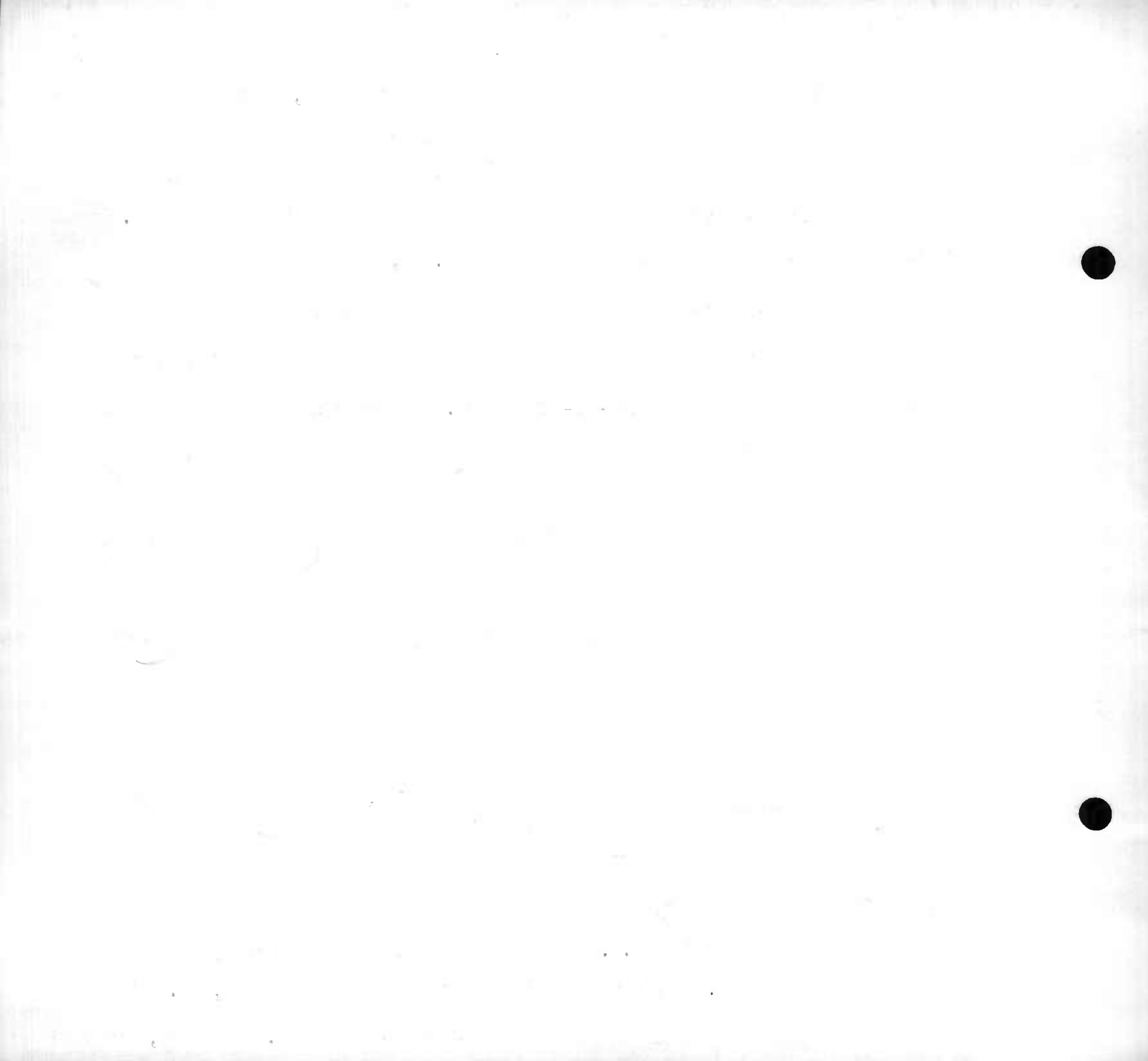
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7745	
CERTIFICATE OF DEATH					
BIRTH NO. W-452 70 7745		1. NAME OF DECEASED (Type or Print) Williams, Mark R.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hosp		2. DATE AND HOUR OF DEATH 7/31/70 1:00 P.M.			
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY Balt Transit Co		8. DATE OF BIRTH 12/16/92	
13. FATHER'S NAME John Williams		14. MOTHER'S MAIDEN NAME Agnes Howard			
15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-9131		17. INFORMANT Mrs Rosa P Williams	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma of colon with intestinal obstruction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 			
(B) DUE TO, OR AS A CONSEQUENCE OF: 		(C) 			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 7/28		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca. Colon		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/24/70 19 70 to 7/31 19 70 and that (I) (we) lost saw the deceased alive on 7/31 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Omar D. Crothers MD				23B. DATE SIGNED 7/31/70	
23C. PHYSICIAN'S NAME (Type) Omar D. Crothers MD				23D. ADDRESS Union Memorial Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/4/70		24C. NAME of CEMETERY or CREMATORY Parkwood	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Farley, R.D.		25C. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

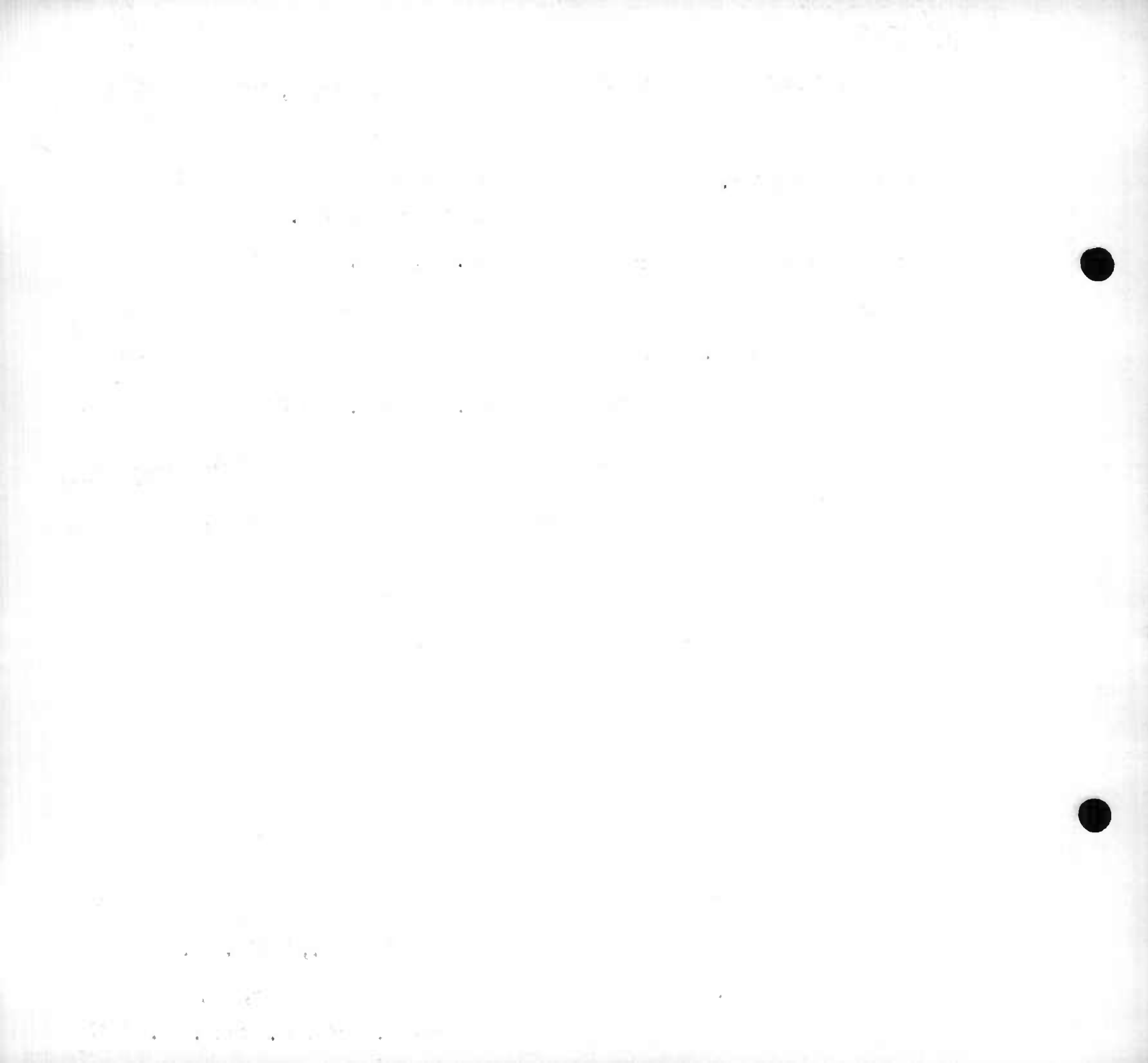
Y-520 70 7746		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7746	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		William Young		August 1, 1970 1:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Gould Convalesarium			A. STATE Maryland		
			B. COUNTY		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2920 Fleetwood Ave.		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 24, 1875	9. AGE (in years last birthday) 94
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Ship Carpenter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Scotland	
13. FATHER'S NAME Robert Young		14. MOTHER'S MAIDEN NAME Mary Pattison			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 268-01-2108		17. INFORMANT Mrs. Loretta Young	
				ADDRESS (Same)	
18. 4444		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]		(A) IMMEDIATE CAUSE Gangrene of rt. lower extremity DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Arterial occlusion DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) Chronic Brain Syndrome Congestive Heart Failure year.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/6/1969 to 8/1/1970 that (I) (we) last saw the deceased alive on 7/31/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Albert B Bradley				23B. DATE SIGNED 8/3/70	
23C. PHYSICIAN'S NAME (Type) Albert B Bradley M.D.				23D. ADDRESS 4900 Belair Rd Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/4/70.		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md. 21214	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland	



FUNERAL DIRECTOR: IMPORTANT

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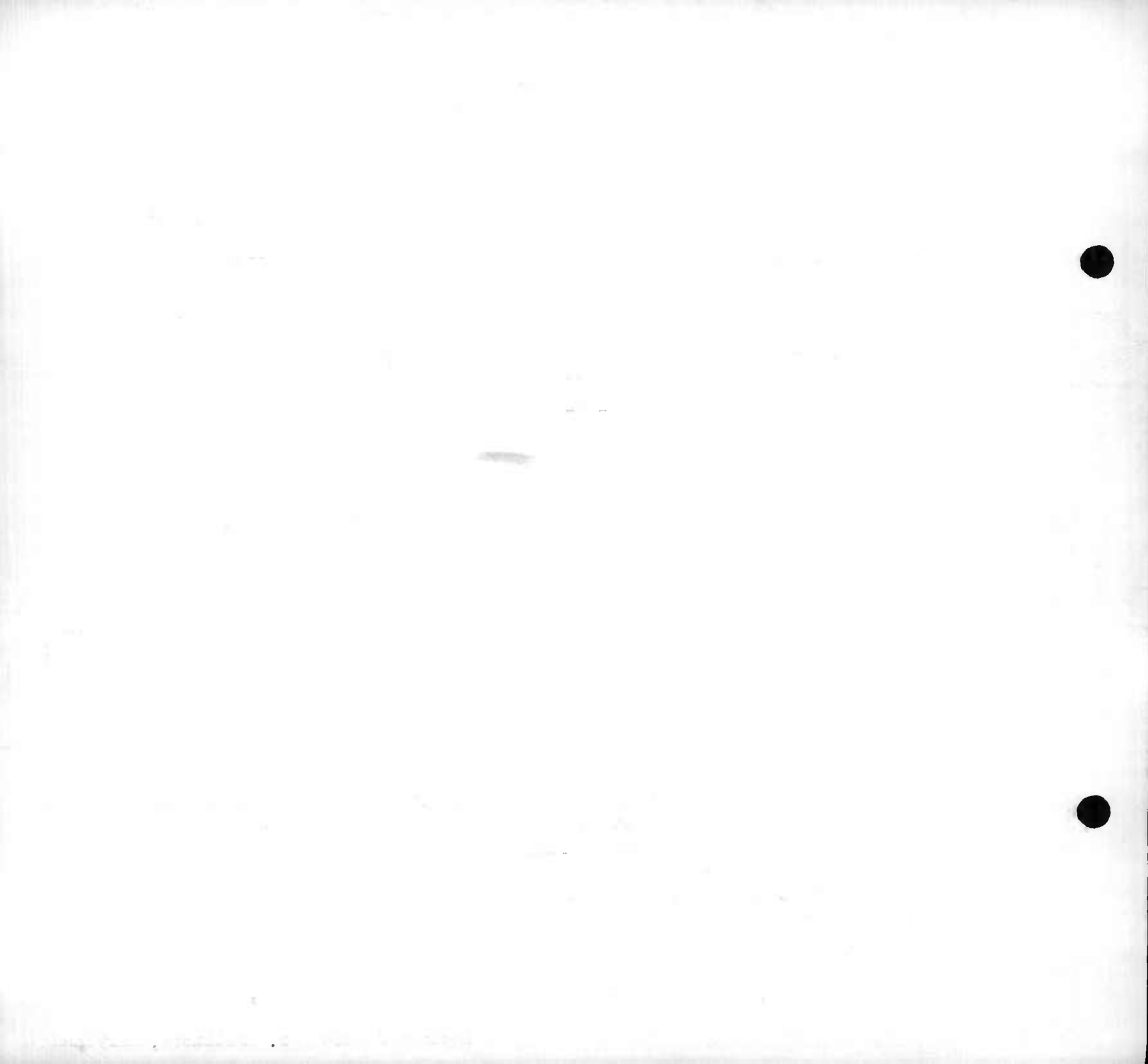
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7747</u>	
BIRTH NO. <u>H-512</u>		70 7747		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Dottie H ampsher</u>			2. DATE AND HOUR OF DEATH <u>August 1, 1970</u> <u>8 4</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2805 Southern Ave.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2733</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2805 Southern Ave.</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 14, 1869.</u>	9. AGE (in years last birthday) <u>100</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William A. Alban</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Hoover</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Wilbur N. Hoshall</u> ADDRESS (Same)		
18. <u>437.19</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Central Venous Accidents</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Central Arteriosclerosis</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u> 20A. AUTOPSY? (Yes or No) <u>no</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u> 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>Jan 1940</u> to <u>August 1, 1970</u> that (I) (we) last saw the deceased alive on <u>July 31, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <u>G. J. Sawyer Jr. M.D.</u> 23B. DATE SIGNED <u>8/3/70</u> 23C. PHYSICIAN'S NAME (Type) <u>G. J. SAWYER JR. M.D.</u> 23D. ADDRESS <u>4808 Harford Rd., Balto. Md.</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>8/4/70.</u> 24C. NAME OF CEMETERY OR CREMATORY <u>Middletown Methodist Cemetery</u> 24D. LOCATION (City, town, or county) (State) <u>Freeland, Md.</u> 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 5 1970</u> 25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u> 25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u> 25D. ADDRESS <u>Balto. Md. 21214</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7748	
N-242 70 7748		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) HARRY M. NICHOLS Sr		2. DATE AND HOUR OF DEATH Aug 2, 1970 3:00 PM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hosp. 44		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland B. COUNTY Baltimore	
				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4820 Roland Ave Apt B					
5. SEX m	6. RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/15/82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Sales		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) 87	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME Wilson B Nichols		14. MOTHER'S MAIDEN NAME Alice V Arnold			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-5765		17. INFORMANT Mr John B Nichols	
				ADDRESS Same	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH myocardial failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cardiogenic shock - AMI (B) DUE TO, OR AS A CONSEQUENCE OF: ? (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Congestive Heart failure & pulmonary embolism					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 29 19 70 to Aug. 2 19 70 that (I) (my) last saw the deceased alive on Aug 2 19 70 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David J. Powner, M.D.		23B. DATE SIGNED Aug. 2, 1970			
23C. PHYSICIAN'S NAME (Type) David J. Powner M.D.		23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/70		24C. NAME OF CEMETERY OR CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. LOCATION (City, town, or county) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Baltimore, Maryland	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-400 70 7749		BALTIMORE CITY HEALTH DEPARTMENT		70 7749	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
MARY ETHEL SOULE			Aug. 1, 1970 1 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 3924 Cloverhill Road			Maryland		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3924 Cloverhill Road		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
female	caucasian	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10-31-87	82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
housewife, retired			Penna.		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
James G. WOODROW			Grace McKewnon		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
			XXX-		Mr. John W. Soule
18. 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Sudden		
II			May years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Jan 7-1963 to July 2 1970 that (I) (we) last saw the deceased alive on July 2 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. McLean				Aug 3-70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. McLean		Medical Arts Building, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/5/70		Druid Ridge	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 5 1970		Robert E. Taylor, Md.		Leonard J. Ruck, Inc. - Balto, Md. - 14	



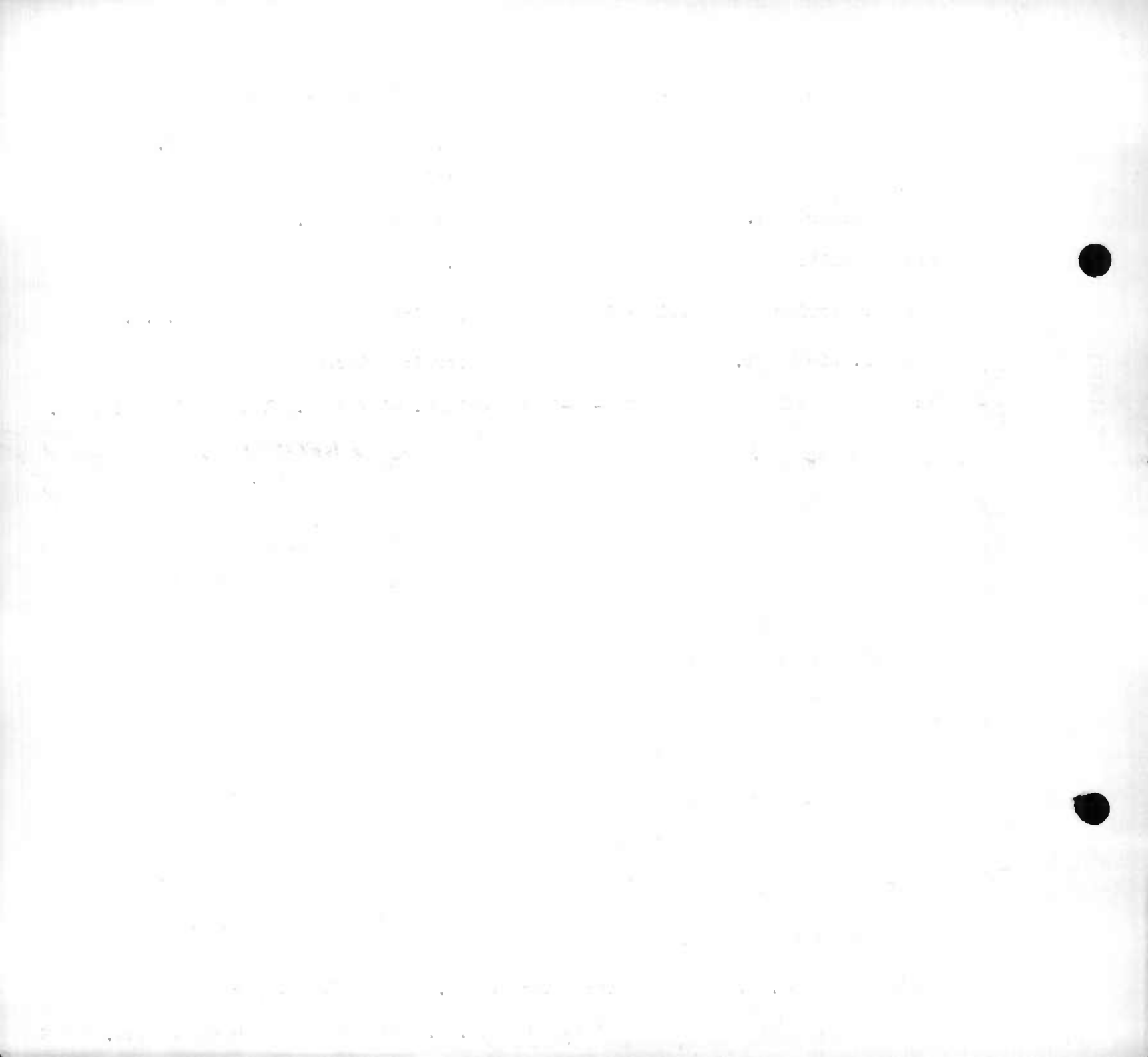
L-2401

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 70 7750

BIRTH NO. 170 7150		DEATH NO. 70 7150	
1. NAME OF DECEASED (Type or Print) John Dallas Lickle		2. DATE AND HOUR OF DEATH August 2, 1970 11:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1631 Harford Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY (Baltimore City) C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1631 Harford Ave.	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1884
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Letter Carrier		10B. KIND OF BUSINESS OR INDUSTRY Post Office	9. AGE (In years last birthday) 85
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John D. Lickle Sr.		14. MOTHER'S MAIDEN NAME Fannie Triakle	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 215-09-1732	
17. INFORMANT John D. Lickle Jr.		ADDRESS Wheel Road Belair, Md.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Chronic obstructive pulmonary disease and pulmonary emphysema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) congestive heart failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several years several years several years			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1954 to Aug 2 19 70 that (I) (we) last saw the deceased alive on Aug 1 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Seymour H. Rubin		23B. DATE/SIGNED 8/4/70	
23C. PHYSICIAN'S NAME (Type) Seymour H. Rubin		23D. ADDRESS 5415 Park Heights Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 5, 70	
24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Taber, M.D.	
25C. FUNERAL DIRECTOR Wm. E. Johnson		ADDRESS 8521 Loch Raven Blvd. 21204	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7751

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

NOVELLA JONES

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 JOHNS HOPKINS HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

July 28, 1970

10:30 A.

5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1001

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

10. AGE (In years
lost birthday)

58

If Under 1 Yr. If Under 24 Hrs.

Months

Days

Hours

Min.

E. STREET AND NUMBER

1911 W. Mulberry Street

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF

WHAT COUNTRY? A

13. FATHER'S NAME

???

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

????

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

M^{rs} toby Smith, same

19.

4319 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Infarction of Brain Stem
(Pons and Medulla Oblongata)APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/29/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/5/70

24C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

24D. LOCATION

(City, town, or county)

A A County M

(State)

25A. DATE REC'D BY HEALTH DEPT

AUG 5 1970

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Adolphus Halstead 1200 W

ADDRESS

North Ave

Letter from M.E.'s office 8-24-70 M.H.

FUNERAL DIRECTOR: IMPORTANT

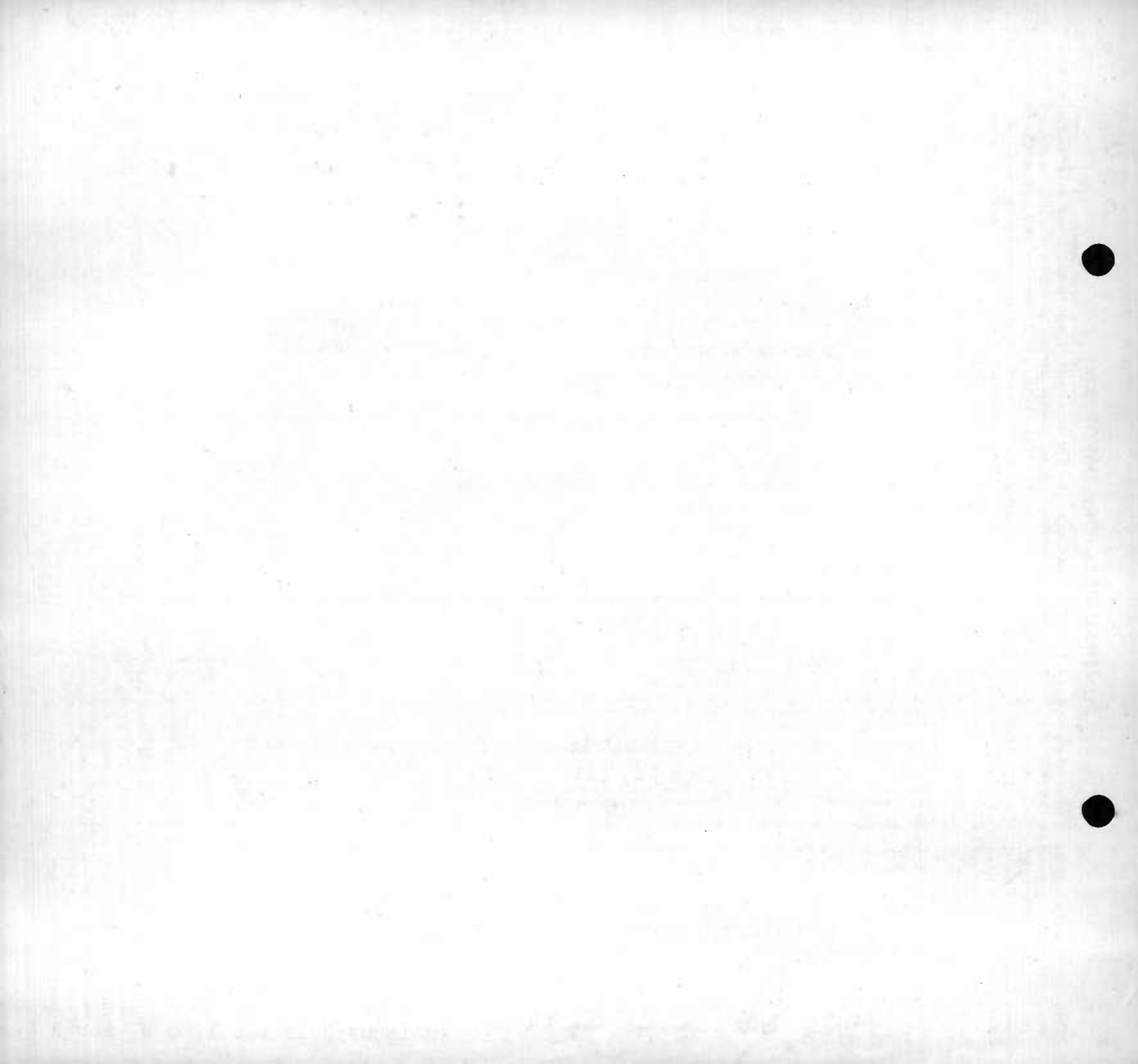
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 70 7752

BIRTH NO. <u>70 7752</u>		1. NAME OF DECEASED (Type or Print) <u>Porter Valentine</u>		2. DATE AND HOUR OF DEATH <u>8-1-70</u> <u>12:30 AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2101</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Mt Siani Nursing Home</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4613 Beck Heights</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>213 SCOTT ST.</u>					
5. SEX <u>M</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) <u>37</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>					
13. FATHER'S NAME <u>Roy Gamble Valentine</u>			14. MOTHER'S MAIDEN NAME <u>Ella May Gamble</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> , ADDRESS	
18. <u>30321</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Brain damage</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cardiac standstill</u> <u>Alcoholic myocarditis</u> <u>Pneumonia</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Brain damage</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac standstill</u> (C) <u>Alcoholic myocarditis</u> <u>Pneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>4 hrs</u> <u>7 yrs</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>7/28</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Anemia</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/28</u> <u>1970</u> to <u>8/1</u> <u>1970</u> , that (I) (we) last saw the deceased alive on <u>7/31</u> <u>1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>V. D. Stitt</u>		23D. ADDRESS <u>206 S. Gilman St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/1/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt Calvary Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>A A County M</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 5 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Tabor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u> ADDRESS <u>1206 W north Ave</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 7753	
BIRTH NO. 70 7753					
1. NAME OF DECEASED (Type or Print) SHIPLEY, ERNEST		2. DATE AND HOUR OF DEATH August 2, 1970 12:55 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 12 Sinai Hospital of Baltimore		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 12 Sinai Hospital of Baltimore		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4341 Reisterstown Rd.			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/5/04	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Handler		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Joshua Shipley		14. MOTHER'S MAIDEN NAME Sarah		ADDRESS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 217-09-4725		16. SOCIAL SECURITY NO. 217-09-4725		17. INFORMANT Miss Mathews,	
18. 011.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebrovascular accident		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Post-operative pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Upper lobectomy for pulmonary TB		(B) DUE TO, OR AS A CONSEQUENCE OF: 8 days		(C) 8 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 7/24/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pulmonary tuberculosis		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 14 1970 to Aug 2 1970 and that (I) (we) lost saw the deceased alive on Aug 2 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Albert L. Manner M.D.				23B. DATE SIGNED 8/2/70	
23C. PHYSICIAN'S NAME (Type) Albert L. Manner M.D.				23D. ADDRESS 6215 A Dimble Rd., Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/6/70		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A A County M.					
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W north A'e	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 70 7754

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARTIN, JOHN		2. DATE AND HOUR OF DEATH AUGUST 4, 1970 6:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE BALTIMORE, MARYLAND B. COUNTY 501			
FULL NAME OF HOSPITAL OR INSTITUTION HOUSE IN THE PINES BELVEDERE 2525 WEST BELVEDERE AVENUE BALTIMORE, MARYLAND 21215		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 609 Aisquith St.			
5. SEX MALE	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1896	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Anne Arundel Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Martin		14. MOTHER'S MAIDEN NAME Edith	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W. I		16. SOCIAL SECURITY NO. 218-05-2919		17. INFORMANT Hester Martin ADDRESS 1206 Short Ct. Apt. C-1	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Primary lung carcinoma (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months 8 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/11 1970 to Aug 4 1970 , that (I) (we) last saw the deceased alive on August 3 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.					
23A. SIGNATURE Alan B. Cohen		23B. DATE SIGNED August 4, 1970		23C. PHYSICIAN'S NAME (Type) ALAN COHEN M.D.	
23D. ADDRESS MARYLANDER APARTMENTS		23E. ADDRESS MARYLANDER APARTMENTS		23F. ADDRESS MARYLANDER APARTMENTS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/70		24C. NAME OF CEMETERY or CREMATORY Loudon Park Nat'l Cem.	
24D. LOCATION Baltimore, Maryland		24E. LOCATION Baltimore, Maryland		24F. LOCATION Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Kelson F.H. ADDRESS 1348 N. Calhoun St.	

FUNERAL DIRECTOR: IMPORTANT

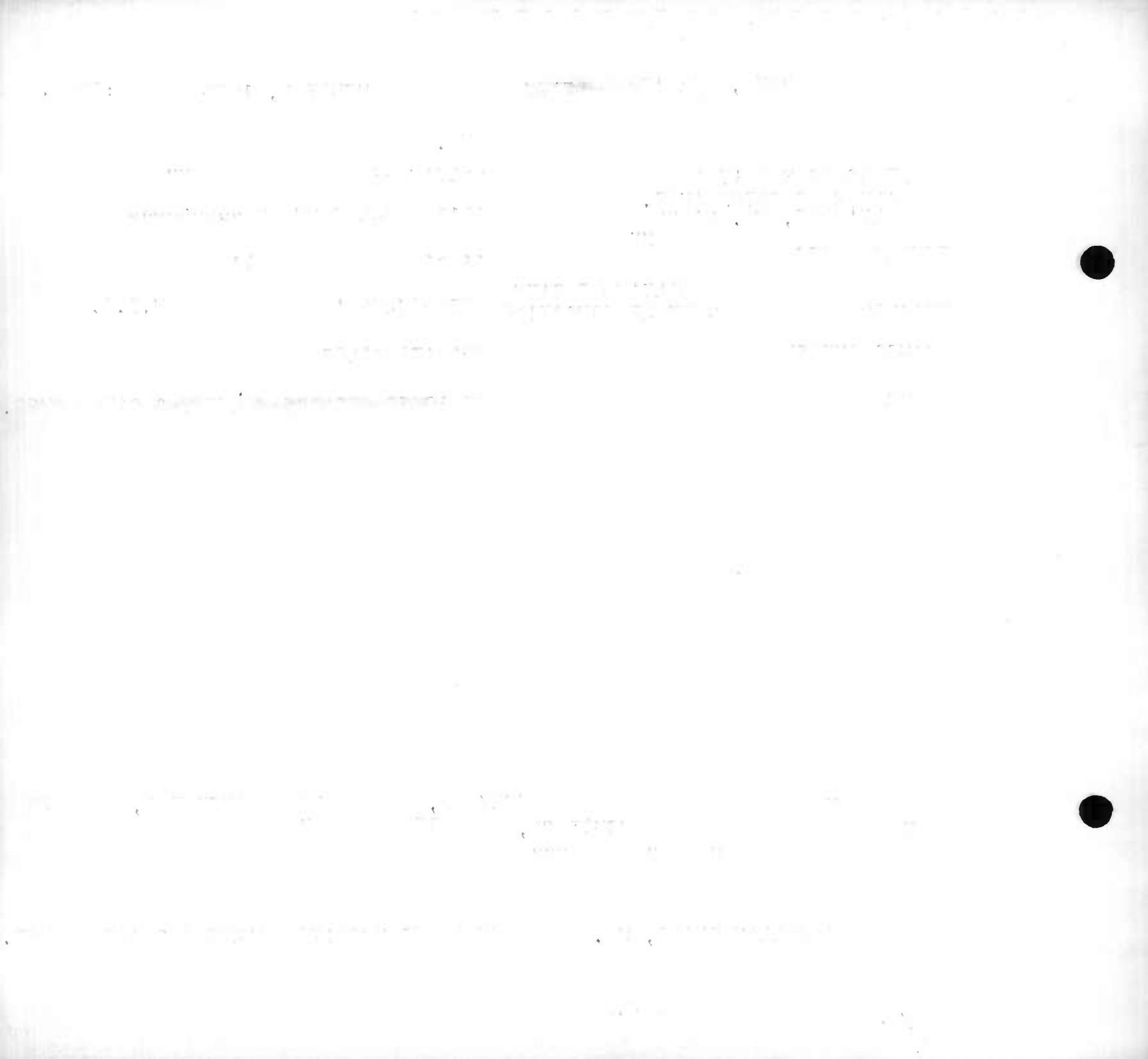
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
70 7755		70 7755		70 7755	
BIRTH NO. <u>M-622</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>MARQUIS EDGAR</u>			2. DATE AND HOUR OF DEATH <u>8/1/70 3 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Pleasant Manor Nursing Home</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md</u> B. COUNTY <u>401</u>		
			C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>12 Park Ave</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-20-25</u>	9. AGE (In years last birthday) <u>45</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Woonsocket, RI</u>	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes April '46 - April '55</u>			16. SOCIAL SECURITY NO. <u>038-14-0373</u>		17. INFORMANT <u>Charles Nedymski - 10 Spruce St. Mansville, RI</u>
18. <u>7-3-81</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinomatosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 [A]. <u>Carcinoma of Colon</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>26 months</u> <u>2 yrs</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <u>7/27</u> 19 <u>70</u> to <u>8/1</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>7/27</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harvey S. Feuerman</u>			23B. DATE SIGNED <u>8/1/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Harvey S. Feuerman</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>8/2/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Loaden National Cem.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 5 1970</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>George L. Schwartz, Inc.</u>
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 7756		70 7756	
BIRTH NO. 8-620				70 7756		70 7756	
CERTIFICATE OF DEATH				REG. NO.		70 7756	
1. NAME OF DECEASED (Type or Print) Juanita E. Burke				2. DATE AND HOUR OF DEATH AUGUST 2, 1970 8:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) & COUNTY MD. 2037			
5. SEX FEMALE				6. RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11 23 28				9. AGE (In years last birthday) 41		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER				10B. KIND OF BUSINESS OR INDUSTRY BALTIMORE CITY DEPT OF EDUCATION		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JAMES BUTLER			
14. MOTHER'S MAIDEN NAME JUANITA DALES				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.				17. INFORMANT Mr. Bernie L. Burke			
18. CAUSE OF DEATH 436.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. C.V.A. + Respiratory arrest. Hypertension.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 26, 1970 to AUGUST 2, 1970 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on AUGUST 02, 1970 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE A. Shams, MD				23B. DATE SIGNED 8-2-70		23C. PHYSICIAN'S NAME (Type) ABDOLLAH SHAMS, MD.	
23D. ADDRESS ST AGNES HOSPITAL WILKENS & CATON AVES.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8/7/1970		24C. NAME OF CEMETERY OR CREMATORY Eden Cemetery	
24D. LOCATION (City, town, or county) (State) Philadelphia Pa.				25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.				25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE			



H-320

70 7757

BALTIMORE CITY HEALTH DEPARTMENT

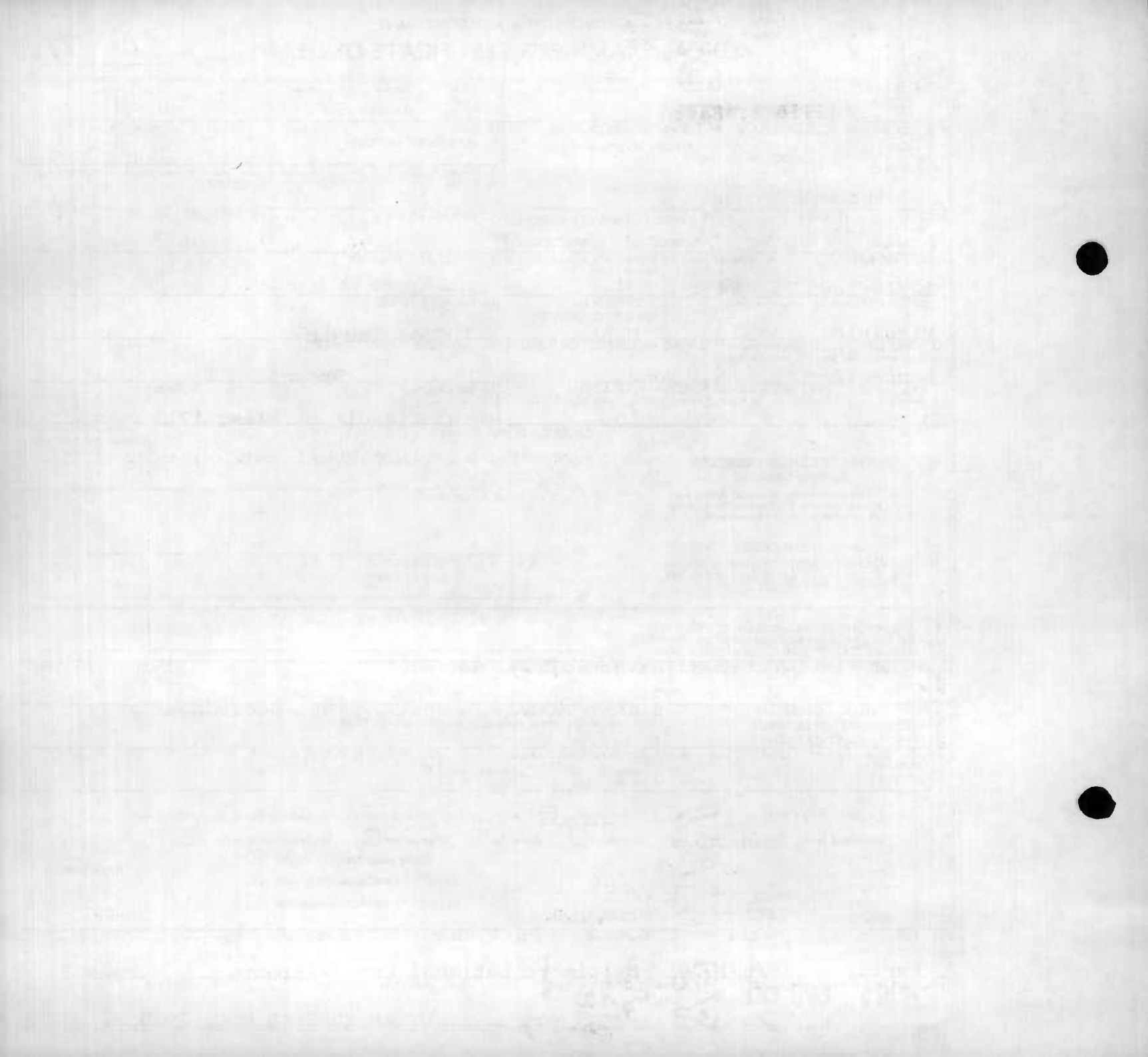
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 7757

BIRTH NO.

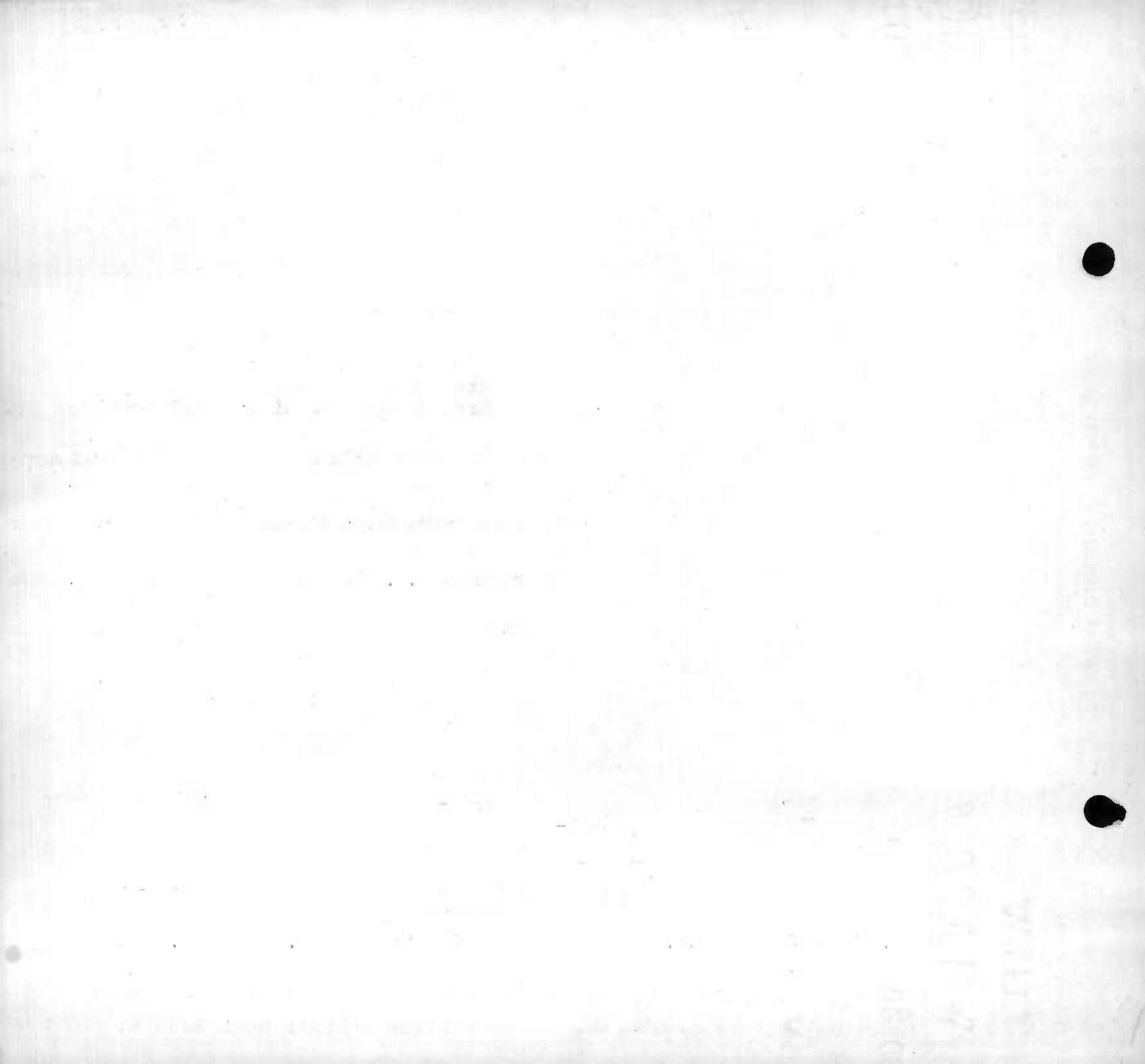
1. NAME OF DECEASED (Type or Print) Lillie B. Hatch		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 2 1970 12:51 A.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 12/10/1885		10. AGE (In years last birthday) 84	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY Home	
15. MOTHER'S MAIDEN NAME Brown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Claudia M. Fleet	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive & arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) no	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-2-70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/1970	
24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE RECD BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Isidore Mihalakis	
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		ADDRESS 3035 W. NORTH	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7758	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) MARY RINGGOLD			2. DATE AND HOUR OF DEATH 7-31-70 7 ¹⁵/_A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Belton Hill Nursing Home			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1403		
5. SEX F 6. RACE N 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 2-22-90 9. AGE (In years last birthday) 80		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10B. KIND OF BUSINESS OR INDUSTRY Dept. Store		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME ARTHUR JEFFERSON			14. MOTHER'S MAIDEN NAME MARGARET TAYLOR		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 217-07-1554		
17. INFORMANT Mrs. Gwendola Logan Mrs. Lillie M. Mills 1817 McCulloh St.			ADDRESS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: congestive heart failure arteriosclerotic heart disease Hypertensive C.V. disease		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). nephrosclerosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several months several months several months several months		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-17 19 69 to 7-31 1970 that (I) (we) last saw the deceased alive on 7-30 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Ellsworth Cook				23B. DATE SIGNED 7-31-70	
23C. PHYSICIAN'S NAME (Type) E. ELLSWORTH COOK M.D.				23D. ADDRESS 2431 Maryland Ave. Balto Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/3/1970		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970 25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			
25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AV					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
REG. NO. [REDACTED]									
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>Bertha Owigley</i>		2. DATE AND HOUR OF DEATH <i>7/30/1970</i> <i>9:15 P.M.</i>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>Hood Convalescent Home</i>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE _____ B. COUNTY _____ C. CITY OR TOWN <i>Balto. Md</i>			
5. SEX <i>Female</i>						6. RACE <i>Caucasian</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>March 15-1887</i>		9. AGE (In years last birthday) <i>83</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>✓</i>		11. BIRTHPLACE (State or foreign country) <i>✓</i>		12. CITIZEN OF WHAT COUNTRY? <i>✓</i>	
13. FATHER'S NAME <i>Walter Owigley</i>						14. MOTHER'S MAIDEN NAME <i>Alice Dashiell</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>						16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT ADDRESS _____	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> (A) IMMEDIATE CAUSE <i>Circulatory and Respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF: <i>CVA</i> </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hrs.</i> <i>Months</i> <i>Years</i> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 60%;"> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>ASCVD</i> </div> <div style="width: 35%;"> <i>Years</i> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 60%;"> (C) DUE TO, OR AS A CONSEQUENCE OF: <i>CBS</i> </div> <div style="width: 35%;"> <i>Years</i> </div> </div>									

BIRTH NO. <u>70-11523</u>				REG. NO. <u>70 7760</u>			
1. NAME OF DECEASED (Type or Print) <u>TIMOTHY SPENCER III.</u>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hospital</u>				3. DATE PRONOUNCED DEAD Month Day Year Hour <u>7 31 1970 9:15 A.</u> M.			
				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>806</u>			
6. SEX <u>Male</u>	7. RACE <u>Negro</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <u>July 4, 1970</u>		10. AGE (In years lost birthday) <u>27</u>		E. STREET AND NUMBER <u>2041 E. North Ave.</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF <u>U.S.A.</u>		13. FATHER'S NAME <u>Timothy Spencer Jr.</u>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <u>Mildred Rose</u>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <u>Mildred Spencer 2041 E. North Ave.</u>			
19. <u>795X</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE Sudden Death in Infancy DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <u>yes</u>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Isidore Mihalakis</u> M.D. EXAMINER'S NAME (Type) <u>Isidore Mihalakis, M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8-1-70</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/4/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Balto. National Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 5 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Milton E. Clickson 1297 Guilford</u>			

NO. 1

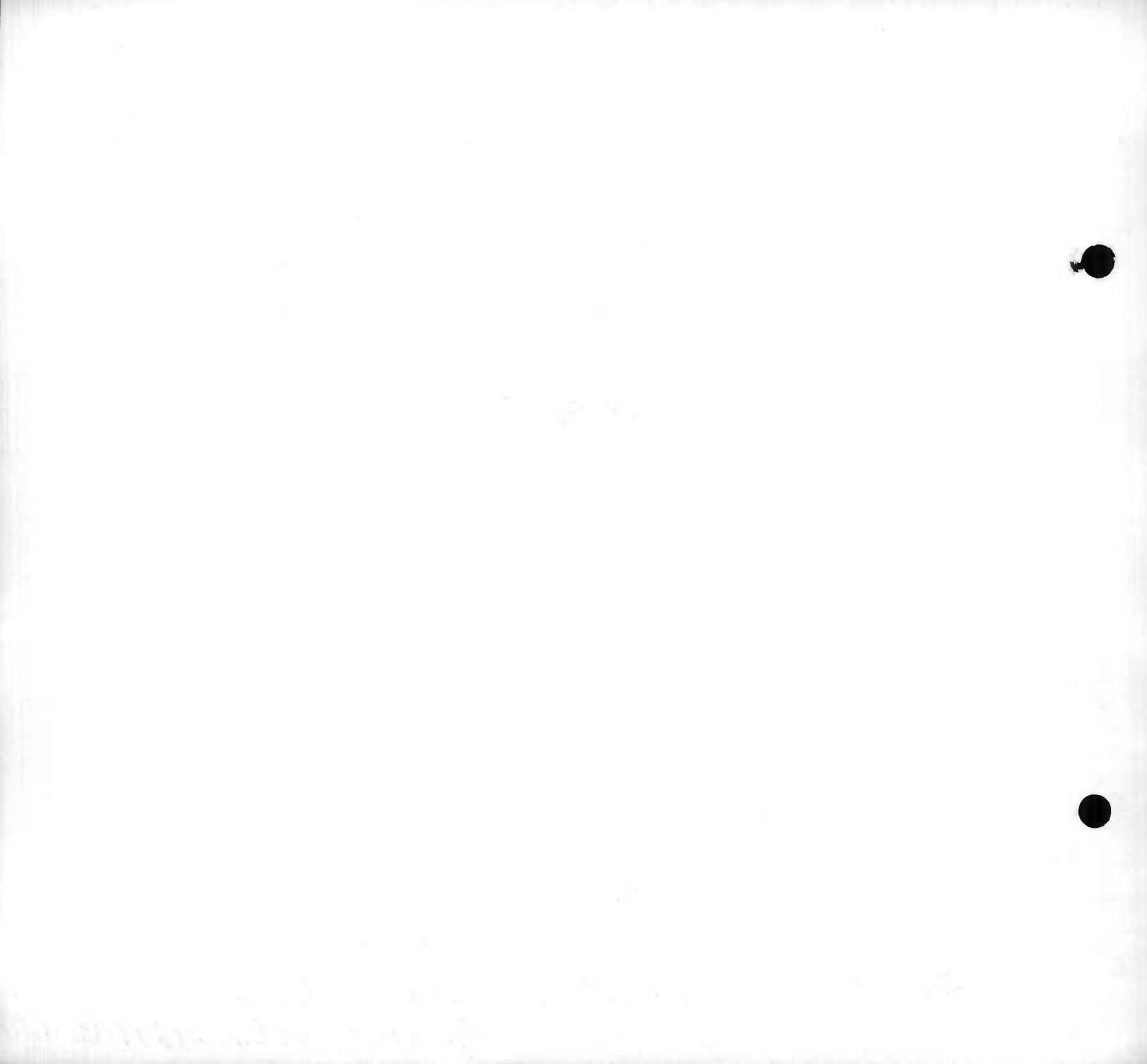
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-236 70 7761		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7761	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMES A. WESTRY		2. DATE AND HOUR OF DEATH August-1-70 12 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Maryland Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BAC - 906		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator Ruth Steel Co.		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 7-12-12 9. AGE (In years last birthday) 58	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? yes -		13. FATHER'S NAME John B. WESTRY	
14. MOTHER'S MAIDEN NAME MATTIE TAYLOR		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 240-092250 Hospital chart.	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Upper GI. bleeding - Acute Peptic ulcer - bleeding		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24h -	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) A Tuberculum Sella Meningioma		10 years at last	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION Jul-23-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Removal of Meningioma		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July-9-70 19 to Aug-1-70 19 that (I) (we) last saw the deceased alive on August 1, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ORDONEZ MD.		23B. DATE SIGNED August-1-70		23C. PHYSICIAN'S NAME (Type) JORGE R. ORDONEZ MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/70		24C. NAME OF CEMETERY or CREMATORY Arlington Memorial Park	
24D. LOCATION Arlington Md.		25A. DATE REC'D BY HEALTH/DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Fisher, MD.	
25C. FUNERAL DIRECTOR Frank J. Ecker		25D. ADDRESS 11297 Columbia		25E. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7762	
X-263 70 7762		BIRTH NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
RICHARDS, THOMAS P		AUGUST 4, 1970 1:20P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		A. STATE MARYLAND B. COUNTY BALTIMORE 5300			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 1209 STELLA DR			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04/25/97	9. AGE (in years last birthday) 73	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CLERK		10B. KIND OF BUSINESS OR INDUSTRY CHEMICAL CO		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM RICHARDS		14. MOTHER'S MAIDEN NAME MAMIE (NEE PEEBLES)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.1		16. SOCIAL SECURITY NO. 219-18-2981		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS	
18. 447.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Dissecting Aortic Aneurysm		Hours	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ASCVD - Aortic Stenosis		Years	
		(C) Pulmonary embolism		2 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Thrombophlebitis		3 days	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from AUGUST 2 19 70 to AUGUST 4 19 70 that (I) (we) last saw the deceased alive on AUGUST 4 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 08 04 70	
23C. PHYSICIAN'S NAME (Type) RALPH UDDIKE M.D.				23D. ADDRESS #304 WILKENS & PINE HGHTS AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/70		24C. NAME OF CEMETERY or CREMATORY Hillcrest Cemetery	
24D. LOCATION (City, town, or county) (State) Cumberland, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970			
25B. NAME OF REGISTRAR Robert E. Fabe, M.D.		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave., 21228			

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BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 70 7763			
BIRTH NO.											
1. NAME OF DECEASED (Type or Print) Richard Harmon						2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month 8 Day 3 Year 70 Hour 9:35 p.m.					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital						3. DATE PRONOUNCED DEAD Month 8 Day 3 Year 70 Hour 9:35 p.m.					
						5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 1538					
6. SEX male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH 21/1/14 12-1-14		10. AGE (In years lost birthday) 55		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Roland Harmon deceased			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				14B. KIND OF BUSINESS OR INDUSTRY Art Plate Glass				15. MOTHER'S MAIDEN NAME Rave			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7/27/42-1/6/46				17. SOCIAL SECURITY NO. 213-03-5424		18. INFORMANT P. O. 235 Mt Pleasant, S. C. Mrs. Edward M. Royall, Jr, 235 Mt Pleasant					
19. CAUSE OF DEATH Multiple injuries DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) yes											
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) Street				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Reisterstown & Belvedere			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 8 3 70 9:05p				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Hit by car while crossing street.			
23. I certify that, held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE [Signature] M.D. DATE SIGNED 8/4/70 EXAMINER'S NAME (Type) Deputy Chief Medical Examiner											
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/70		24C. NAME OF CEMETERY or CREMATORY Baltimore National				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970				25B. NAME OF REGISTRAR Robert E. Farley, M.D.				25C. FUNERAL DIRECTOR ADDRESS Witzke, 1630 Edmondson Ave., 21229			

ACADEMY BOLD

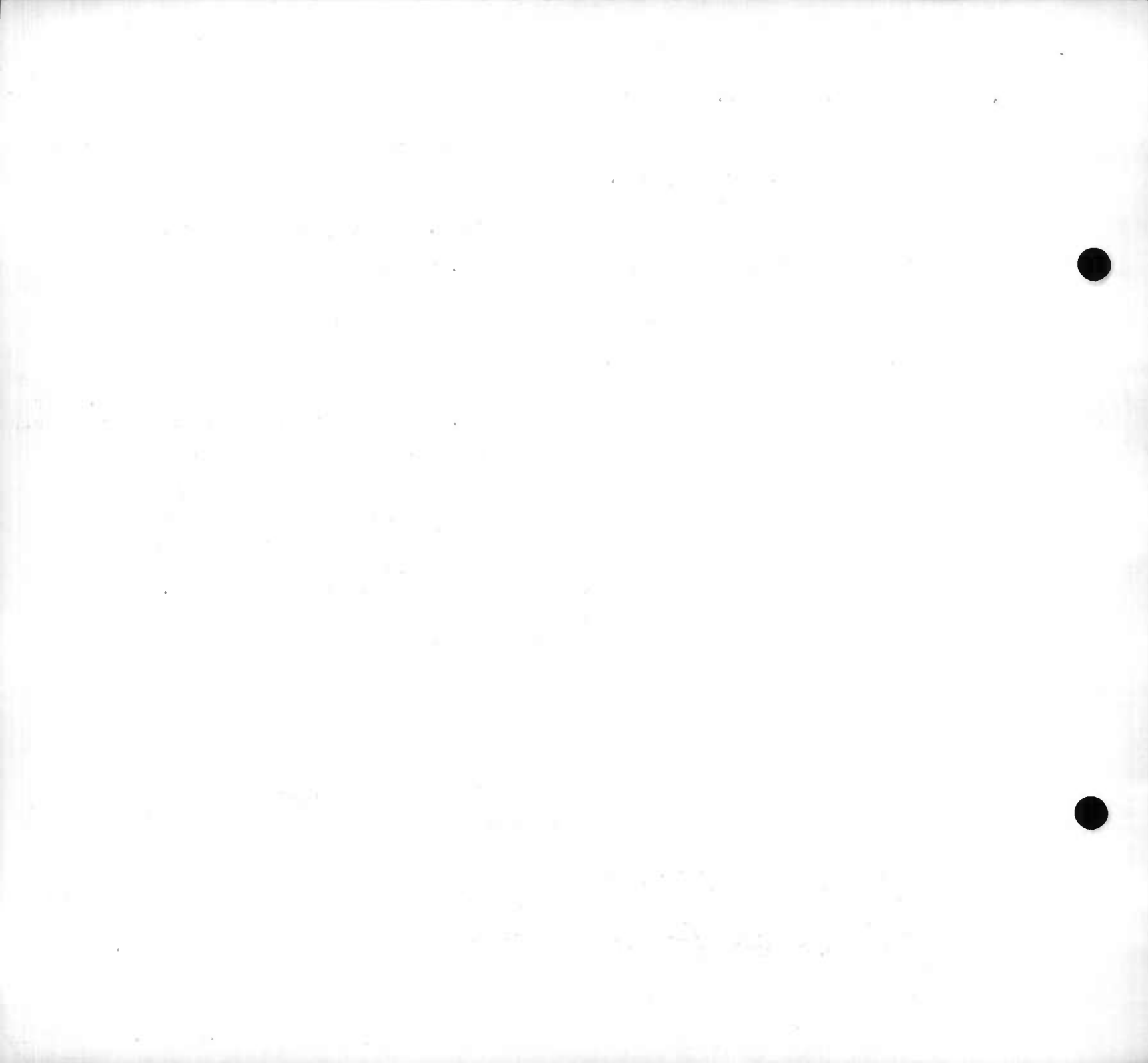
W. T. CORLE

VALLEY PARK, MO.

Attest: Notary Public, Mo. 1930

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-625 70 7764		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7764	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Wilhelmine M. Harrison		August 2, 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland		2047	
00 74 N. Monastery Ave. Baltimore, Maryland 21229		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		74 N. Monastery Avenue		21229	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
Fem	Caucasian	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Mar. 29, 1891	79	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		--		Baltimore, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
August Grebe		Anna ==		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				ADDRESS	
				Baltimore, Md. 21229	
				Mr. Albert R. Harrison, Jr., 74 N. Monastery Ave.	
18. 440.19		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Inferior Page	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) General Enteroviral Disease		DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(C) Disease Degenerative State			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Complete Anemia			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Aug 1 1970 to Aug 1 1970 and that (I) (we) last saw the deceased alive on Aug 1 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Thomas G. Abbott		8-3-70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Thomas G. Abbott, M.D.		4509 Liberty Heights Ave., Balto., Md. 21207			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		8/6/70		Loudon Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 5 1970		Robert E. Searles, Jr.		Witzke, 1630 Edmondson Av., Balto. (Catonsville)	

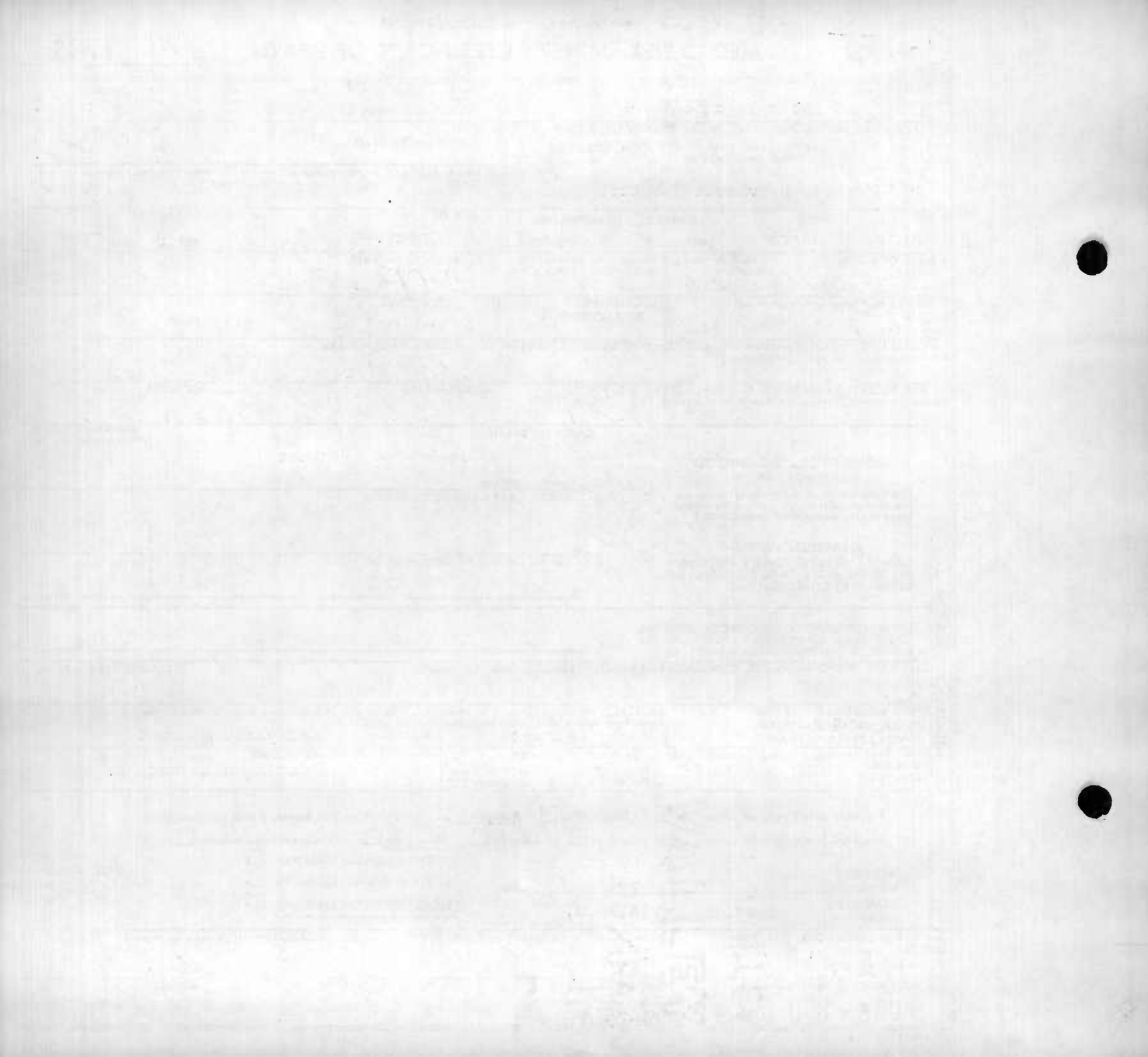


C-455

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7765

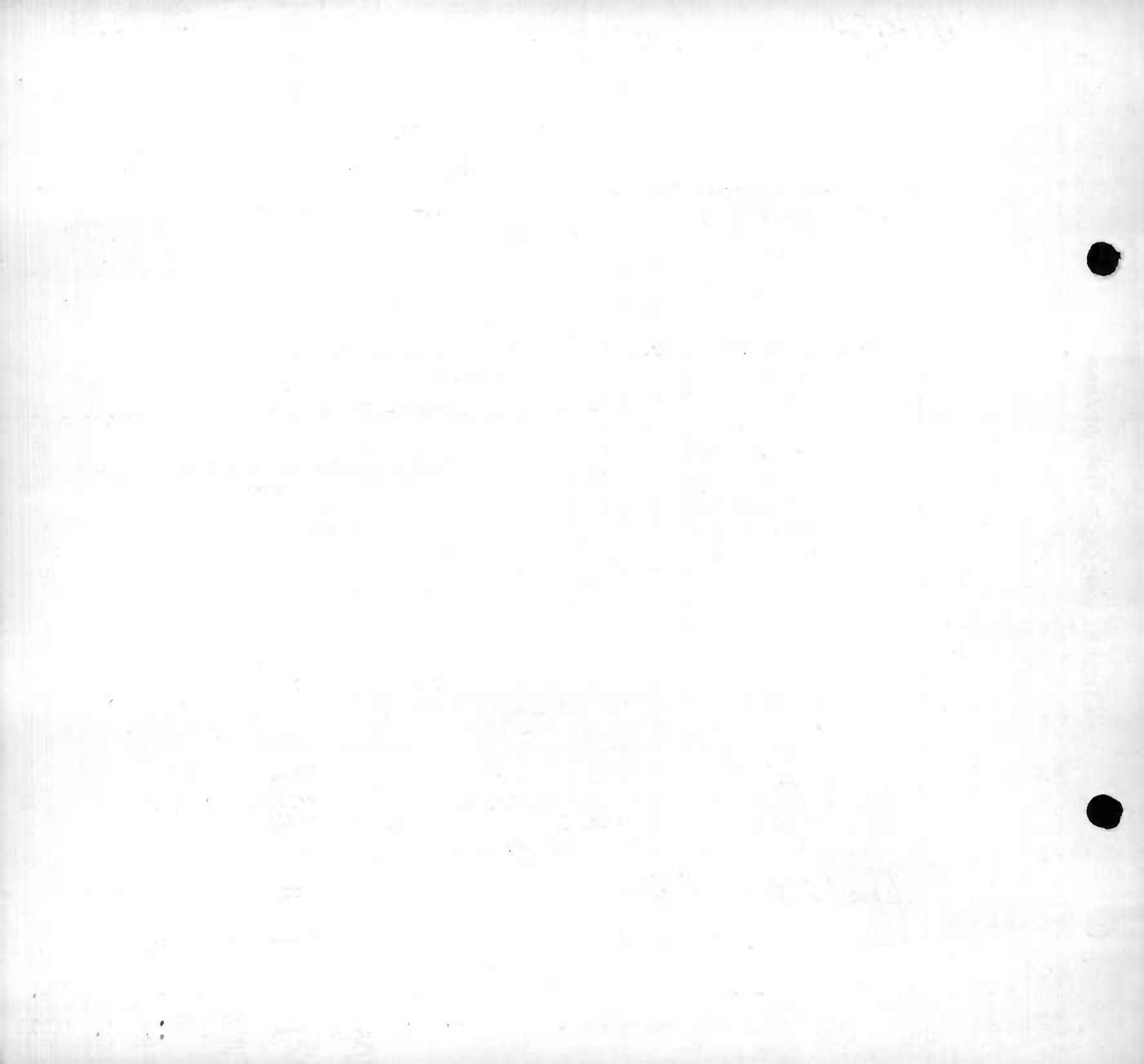
1. NAME OF DECEASED (Type or Print) Clinton Coleman		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month 8 Day 3 Year 70 Hour 7:20 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) Provident Hospital		3. DATE PRONOUNCED DEAD Month 8 Day 3 Year 70 Hour 7:20 a.m.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1502	
9. DATE OF BIRTH 9/1/1940		10. AGE (In years last birthday) 30	
11. BIRTHPLACE (State or foreign country) Liverpool Va		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Manley C Barnes		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Victoria C Barnes		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 231-145322		18. INFORMANT William C. Galt ADDRESS 4229 Lafayette Ave	
19. E966 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Stabwound of chest DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Lafayette & Brunt	
22D. TIME OF INJURY (APPROX.) 8 3 70 7:15a		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Stabbed during altercation.		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Peter Lipkovic EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 8-8-70	
24C. NAME OF CEMETERY or CREMATORY Not Ashburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR William C. Galt		ADDRESS 2302 W. North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

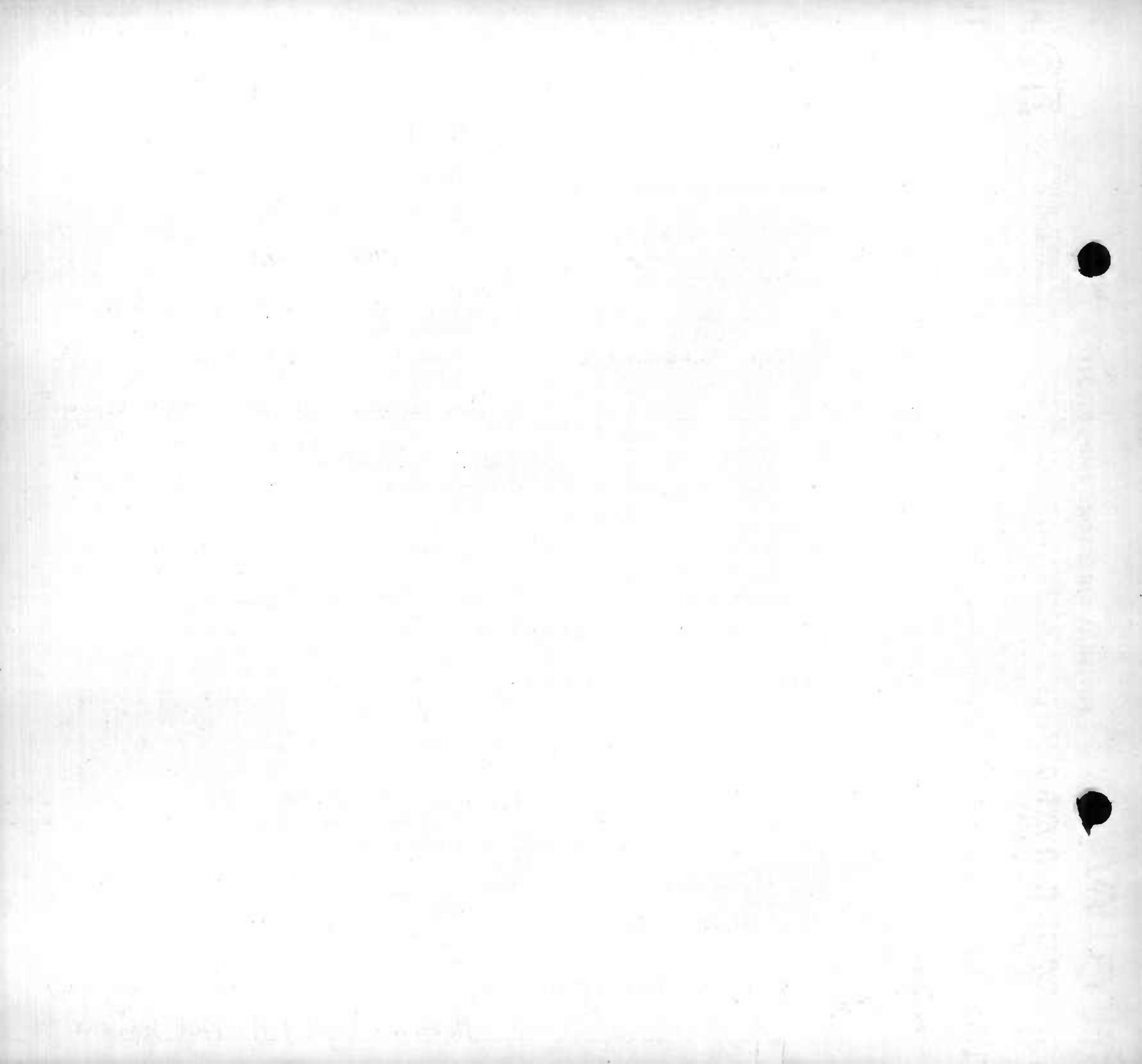
BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO.	
W-452		70 7766		70 7766	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Susan Christine Williams		Aug. 3, 1970		10:25 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
US Public Health Service Hospital 3100 Wyman Parkway		Va.			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Newport News		YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		844- 18th Street			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10/10/50	19	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
none		None		Va.	
12. CITIZEN OF WHAT COUNTRY?		USA			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
James P. Williams, Jr.			Pauline Daniels		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		228-78-0703		Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I		Undifferentiated malignant tumor		Months	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from May 25 19 70 to Aug. 3 19 70, that (1) (we) last saw the deceased alive on Aug. 3 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Samuel P. Ward, M.D.				8/4/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Samuel P. Ward, Surgeon (R)		US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8-7-70		Peninsula Memorial Park Newport News, Va.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 5 1970		Robert E. Taylor, R.D.		H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7767</u>	
J-525 70 7767		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Johnson Mary Coates</u>		2. DATE AND HOUR OF DEATH <u>Aug. 3, '70</u> <u>7:50 PM</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence (before admission) A. STATE B. COUNTY		1547	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital Maryland</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2103 Hilton St</u>		5. SEX <u>female</u>		6. RACE <u>N</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 28, 1900</u>		9. AGE (In years last birthday) <u>70</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Calvert Co, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Washington</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Washington</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Lurene Marshall</u>	
18. <u>157.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Adenocarcinoma of Stomach with metastasis to omentum</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Chronic Heart failure</u>		19. DATE OF OPERATION <u>July 25 1970</u>		20. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 13, 1970</u> to <u>Aug. 3, 1970</u> , that (I) (we) last saw the deceased alive on <u>Aug. 3, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ro M. Duck</u>		23B. DATE SIGNED <u>Aug 3, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>Ro, Myung Duck</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/8/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Family Lot</u>	
24D. LOCATION (City, town, or county) (State) <u>Calvert Co, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 5 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Morton & Dyett F.H.</u>		25D. ADDRESS <u>1701 Laurens St.</u>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7768

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Theodore Laster		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month 8 Day 2 Year 70 Hour 7:30 p. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Lutheran Hospital 9-21-70		3. DATE PRONOUNCED DEAD Month 8 Day 2 Year 70 Hour 7:30 p. M.	
6. SEX male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 10-2-1910		10. AGE (In years lost birthday) 59	
11. BIRTHPLACE (State or foreign country) Atlanta, Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Allen Laster		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker	
15. MOTHER'S MAIDEN NAME Mary Ward		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.	
17. SOCIAL SECURITY NO. 220-09-3699		18. INFORMANT Mrs. Hannah Laster	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of lung with brain metastases (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an inquiry <input type="checkbox"/> inspection <input checked="" type="checkbox"/> autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-6-70	
24C. NAME OF CEMETERY or CREMATORY Western Star Cemetery		24D. LOCATION (City, town, or county) (State) Catonsville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens Street	

V, S. 153

9-21-76

W.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-000		70 7769		BALTIMORE CITY HEALTH DEPARTMENT		70 7769	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <i>Pye, Leroy</i>				2. DATE AND HOUR OF DEATH <i>9:45 PM 8/2/70</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Union Memorial Hospital</i>				C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>2207 N. Fulton Avenue</i>							
5. SEX <i>M</i>	6. RACE <i>negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>03-07-02</i>	9. AGE (In years last birthday) <i>68</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>CHARLES PYE</i>			14. MOTHER'S MAIDEN NAME <i>EMMA LOTTIE</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i>			16. SOCIAL SECURITY NO. <i>218-05-7992</i>		17. INFORMANT <i>wife Mrs. Dorothy Pye</i>		ADDRESS <i>same 2207 N. Fulton Ave</i>
18. <i>470.7 I</i> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <i>myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (M) (this hospital) attended the deceased from <i>7/30</i> 19 <i>70</i> to <i>8/02</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>8/02</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>I. Chalk</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8/02/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>ISSAM E. CHEIKH</i>				23D. ADDRESS <i>Union Memorial Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>8/5/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Western Star Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Catonsville Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 5 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Morton & Dye H.F.H. 1701 Laurens St.</i>			

interfacial lubrication

122411 E 104221

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-520 70 7770		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7770	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MR. JOHN H. AMES		2. DATE AND HOUR OF DEATH 8-2-70 9:40 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		1603	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS HOSPITAL 342025 W. FAYETTE STREET BALTIMORE, MARYLAND		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1625 EDMONDSON AVE		5. SEX Male		6. RACE NEGRO	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/14/88		9. AGE (in years lost birthday) 82 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co.		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME George Ames		14. MOTHER'S MAIDEN NAME Lillian Ames	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6/21/18 - 7/8/19		16. SOCIAL SECURITY NO. 212-05-5283		17. INFORMANT Mrs. Edith Allen	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH Bilateral congestive bronchopneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: poss. T.B. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years ?	
19. DATE OF OPERATION None		20. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from July 26 1970 to Aug 2 1970 that (I) last saw the deceased alive on Aug 2 1970 and that (in my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE Lilia Lofranco M.D.		23B. DATE SIGNED 8-2-70		23C. PHYSICIAN'S NAME (Type) Lilia Lofranco M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/6/70		24C. NAME OF CEMETERY OR CREMATORY Landon Pk. Nat'l Cem.	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Jelen, M.D.	
25C. FUNERAL DIRECTOR Morton E. Dyett F.H.		25D. ADDRESS 1701 Laurens St.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7772	
CERTIFICATE OF DEATH					
BIRTH NO. W-420 70 7772					
1. NAME OF DECEASED (Type or Print) WILKES) RUDOLPH V. WELLS (Wilkes)		2. DATE AND HOUR OF DEATH 7-31-70 9:40 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1606			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL of Maryland		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2663 Edmonson Ave.			
5. SEX M	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-26-33	9. AGE (In years last birthday) 37
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none now		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Chester, South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Willie Gilmore			
14. MOTHER'S MAIDEN NAME Essie Wilkes		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.			
16. SOCIAL SECURITY NO. 248-50-1626		17. INFORMANT Mr. James S. Wilkes			
ADDRESS 506 N. Stricker St.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 303.21 x 250.1		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiac Arrhythmia DUE TO, OR AS A CONSEQUENCE OF: (Ventricular fibrillation & shock)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH at least 12 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Alcoholic myocardialopathy (?)		YEARS.	
(C) Uncontrolled Diabetes Mellitus				YEARS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-31-70 19 70 to 7-31-70 19 70 that (I) (we) last saw the deceased alive on 7-31 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Angelita A. Papano				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ANGE LITA TOPACIO, MD		23D. ADDRESS LUTHERAN HOSP. BALTIMORE.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/70		24C. NAME OF CEMETERY OR CREMATORY Gettysburg Cem.	
24D. LOCATION (City, town, or county) (State) Chester, South Carolina					
25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970		25B. NAME OF REGISTRAR Robert E. Tabor, M.D.		25C. FUNERAL DIRECTOR Morton Dyett F.H.	
ADDRESS 1701 Laurens St.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-120 70 7773		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 7773	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Ruth J. Epps</u>		2. DATE AND HOUR OF DEATH <u>7/31/70</u> <u>4:25 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1504</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Granada Nursing Home</u> <u>90</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>2202 Clifton Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/2/98</u>	9. AGE (In years last birthday) <u>72 yrs.</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Burkeville, Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unk.</u>		14. MOTHER'S MAIDEN NAME <u>Unk.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Fowlkes (sister) 2019 Smallwood Av 21216</u>	
18. <u>436.71</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebrovascular Accident</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Accident</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2/10/70</u> 19 to <u>7/31/70</u> 19 that (I) (we) last saw the deceased alive on <u>7/31/70</u> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>7/31/70</u>			
23C. PHYSICIAN'S NAME (Typo) <u>Harris Sedward</u>		23D. ADDRESS <u>1801 Belting Rd 21209</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Aug 5, 1970</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Jones Cemetery</u>	
24D. LOCATION <u>Burkesville, Va</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 5 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, Md.</u>		25C. FUNERAL DIRECTOR <u>Morton & Dyett F H Baltimore, Md 21217</u>	
25D. ADDRESS					

Carroll County, Md.

no

1/2/72

2/10/72

4/2/72

Mr. [unclear]
[unclear]
[unclear]

~~Mr. [unclear]~~
[unclear]
[unclear]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-520 70 7774				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7774	
BIRTH NO. <u>Willie Thomas</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Lincoln Nursing Home</u>				2. DATE AND HOUR OF DEATH <u>8-1-70</u> <u>6:40 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>70 Lincoln Nursing Home</u>				A. STATE <u>Maryland</u>		B. COUNTY <u>1303</u>	
				C. CITY OR TOWN <u>Baltimore</u>		D. (INSIDE CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2506 Madison Ave</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-14-1892</u>	9. AGE (In years last birthday) <u>78</u>	10. If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Florida</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>183-20-2863</u>		17. INFORMANT ADDRESS <u>Lincoln Nursing Home</u>	
18. <u>433.19</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Thrombosis</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12-15-1959</u> to <u>8-1-1970</u> that (I) (we) last saw the deceased alive on <u>8-1-1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>8-1-70</u>		23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>8/4/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>	
24D. LOCATION (City, town, county) (State) <u>Baltimore, Maryland</u>				25A. DATE REC'D BY HEALTH DEPT. <u>AUG 5 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>				25C. FUNERAL DIRECTOR ADDRESS <u>Morton & Dyett F.H. 1701 Laurens St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

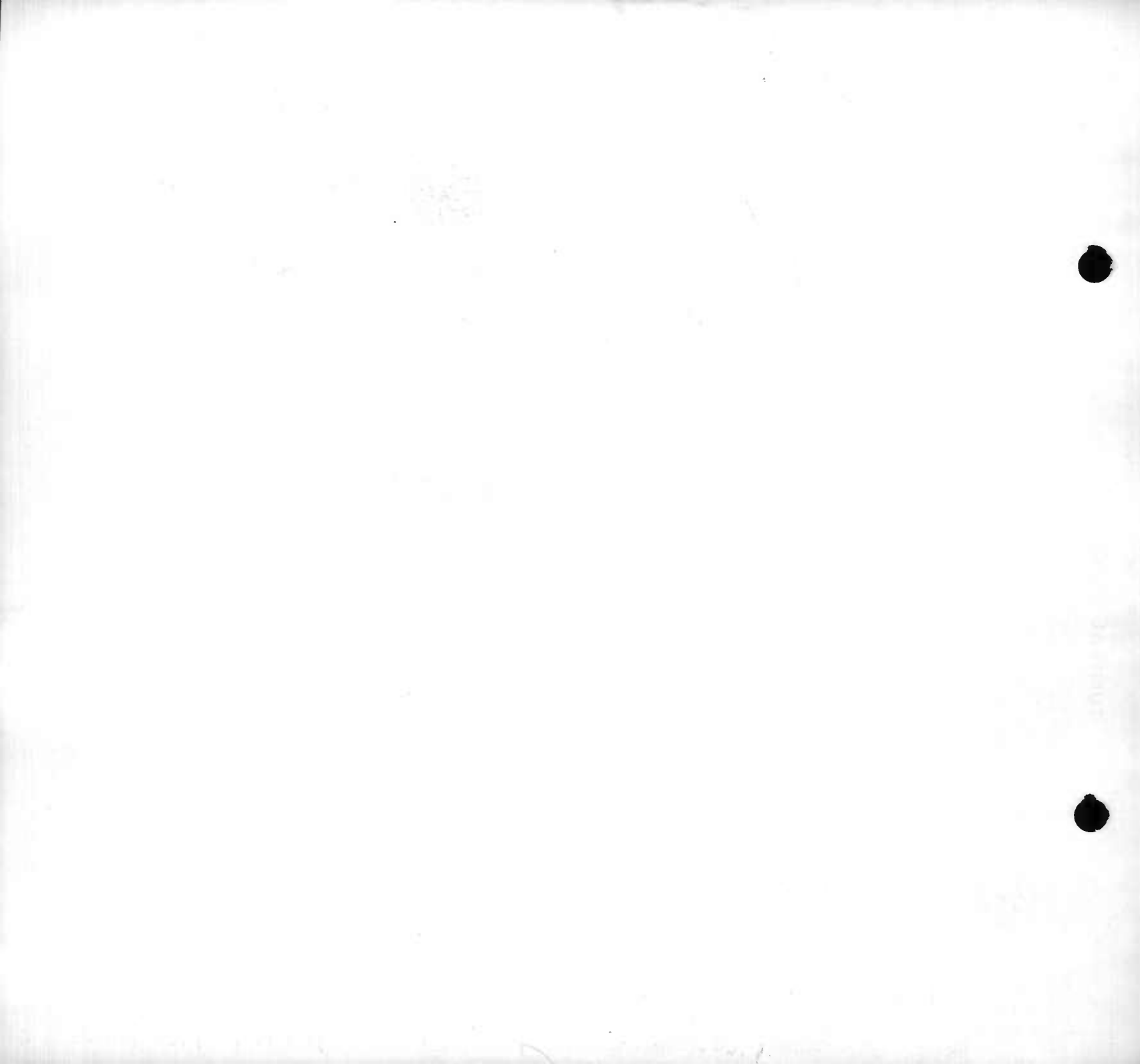
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7775</u>	
W-638		K-360		70 7775	
BIRTH NO.		70 7775		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Kater, Ward</u> (Charles Kater)		2. DATE AND HOUR OF DEATH <u>August 2, 1970</u> <u>12³⁵</u> <u>AM.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI Hospital of Baltimore</u>		A. STATE <u>Md.</u>		B. COUNTY <u>2802</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>3505 Plateau Avenue</u>					
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-1-99</u>	9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hertford, NC</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Horace Ward</u>		14. MOTHER'S MAIDEN NAME <u>Unk.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>224-09-6383</u>		17. INFORMANT <u>367-8426</u> ADDRESS <u>Father- Rev Horce Ward 3505 Plateau Avenue</u>	
18. <u>4-10-71</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac Arrest</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Acute myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(this hospital)</u> attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Leonardo E. Vinuesa</u>		23B. DATE SIGNED <u>Aug 2, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>Leonardo E. Vinuesa</u>	
23D. ADDRESS <u>SINAI Hospital of Baltimore</u>		23E. DEGREE <u>DEGREE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Aug 5, 1970</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetery</u>	
24D. LOCATION <u>Suffolk, Virginia</u>		24E. STATE <u>(City, town, or county) (State)</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 5 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Morton & Dyett F H Baltimore, Md 21217</u>	
25D. ADDRESS <u>Morton & Dyett F H Baltimore, Md 21217</u>		25E. ADDRESS <u>Morton & Dyett F H Baltimore, Md 21217</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7776</u>	
M-231 70 7776				CERTIFICATE OF DEATH	
BIRTH NO. <u>70 7776</u>		1. NAME OF DECEASED (Type or Print) <u>John R. McDuffie</u>		2. DATE AND HOUR OF DEATH <u>Aug. 3, 1970 2:44 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>46 Lutheran Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1503</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2216 Pressman Street</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-8-15</u>	9. AGE (In years last birthday) <u>54</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>United Clay Supply</u>		11. BIRTHPLACE (State or foreign country) <u>Columbia, S. Carolina</u>	
13. FATHER'S NAME <u>Phillip McDuffie</u>		14. MOTHER'S MAIDEN NAME <u>Mattie McDuffie</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes 12/10/42 - 2/26/44</u>		16. SOCIAL SECURITY NO. <u>248-09-7376</u>		17. INFORMANT <u>Mrs. Isabelle McDuffie</u> ADDRESS <u>Same</u>	
18. <u>43191</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (A) IMMEDIATE CAUSE <u>Cerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-2-</u> 19 <u>70</u> to <u>8-3</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Desai</u> <u>M.D.</u> DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>PRAGNA DESAI</u> DEGREE		23D. ADDRESS <u>730 Ashburton St. Baltimore, MD 21216</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>8/7/70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>London Pk Nat'l Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Maryland</u>	
25. DATE REC'D BY HEALTH DEPT. <u>AUG 5 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Morton E. Dyett F.H.</u> ADDRESS <u>1701 Laurens St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7777	
BIRTH NO. 70 7777		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Marie McClure</u>			2. DATE AND HOUR OF DEATH <u>8/4/70</u> <u>4:00 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Maryland General Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1207</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2936 Wyman Pkwy</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5/10/98</u>	9. AGE (In years last birthday) <u>72</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>George M. Shipper Dec.</u>		
14. MOTHER'S MAIDEN NAME <u>Catherine Kremer Dec.</u>			15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>215-09-6588</u>			17. INFORMANT <u>Rose Shipper</u> ADDRESS <u>2936 Wyman Pkwy, Balt.</u>		
18. <u>43371</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(A) IMMEDIATE CAUSE <u>Cerebral thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>a month</u>
			(B) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>?</u>
			(C) _____		
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>July 4</u> 19 <u>70</u> to <u>Aug. 4</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>Aug. 4</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Reizo Tsukamoto M.D.</u>			23B. DATE SIGNED <u>8/5/1970</u>		23C. PHYSICIAN'S NAME (Type) <u>Reizo Tsukamoto M.D.</u>
23D. ADDRESS <u>Maryland General Hospital</u>			24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>8/7/70</u>			24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 5 1970</u>			25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J Ruck Inc.</u> ADDRESS <u>Baltimore, Maryland</u>

4 1/2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 7778		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 7778	
M.E. CASE NO.		1. NAME OF DECEASED Martin CHARLES SCOTT		2. DATE AND HOUR OF DEATH August 2, 1970 4:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hosp.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 611 Park Ave.			
5. SEX Male	6. RACE Cau.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Aug. 12, 1897	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Firefighter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John William Scott		14. MOTHER'S MAIDEN NAME Susie Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 212-34-6225		17. INFORMANT Mrs Genevieve Scott 4258 Sheldon Ave 21206	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) acute myocardial infarction 10 hrs. (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 10 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 2, 1970 to Aug. 2, 1970, that (I) (we) last saw the deceased alive on Aug. 2, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE JAE H. HONG		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Aug. 2, 1970	
23C. PHYSICIAN'S NAME (Type) JAE H. HONG		23D. ADDRESS Maryland General Hospital, Baltimore			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 8-5-70		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 5 1970			
25B. NAME OF REGISTRAR Robert E. Fisher M.D.		25C. FUNERAL DIRECTOR Leonard J Ruck Inc. Balto. Md. 21214			

CERTIFICATE OF DEATH

REG. NO.

70 7779

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Kahler Barbara

2. DATE AND HOUR OF DEATH

8-3-70

4:00P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31
Baltimore City Hospitals
4940 Eastern Ave.
Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN
Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4940 Eastern Ave. 21224

007

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

9-8-91

9. AGE (In years last birthday)

79

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Schmitt

14. MOTHER'S MAIDEN NAME

Mary Lautz

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

217-24-9019

17. INFORMANT

4940 Eastern Ave. ADDRESS

BCH Records: Baltimore, Md. 21224

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Congestive heart failure 2 mos.

(B) DUE TO, OR AS A CONSEQUENCE OF:

ASWD, h/o MI's, vent. aneurysm years

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Parkinson's disease years

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-20 19 69 to Aug-3 19 70. that (I) (we) lost saw the deceased alive on 8-3- 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

G. Alarcón MD

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

8-3-70

23C. PHYSICIAN'S NAME (Type)

GRACIELA S. ALARCÓN

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Ave. Baltimore, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/7/70

24C. NAME OF CEMETERY or CREMATORY

Moreland Memorial Park

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 5 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, MD.

25C. FUNERAL DIRECTOR

Leonard J Ruck Inc. Baltimore, Maryland

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

3508 Glenmore Ave

called hosp.

70 7780

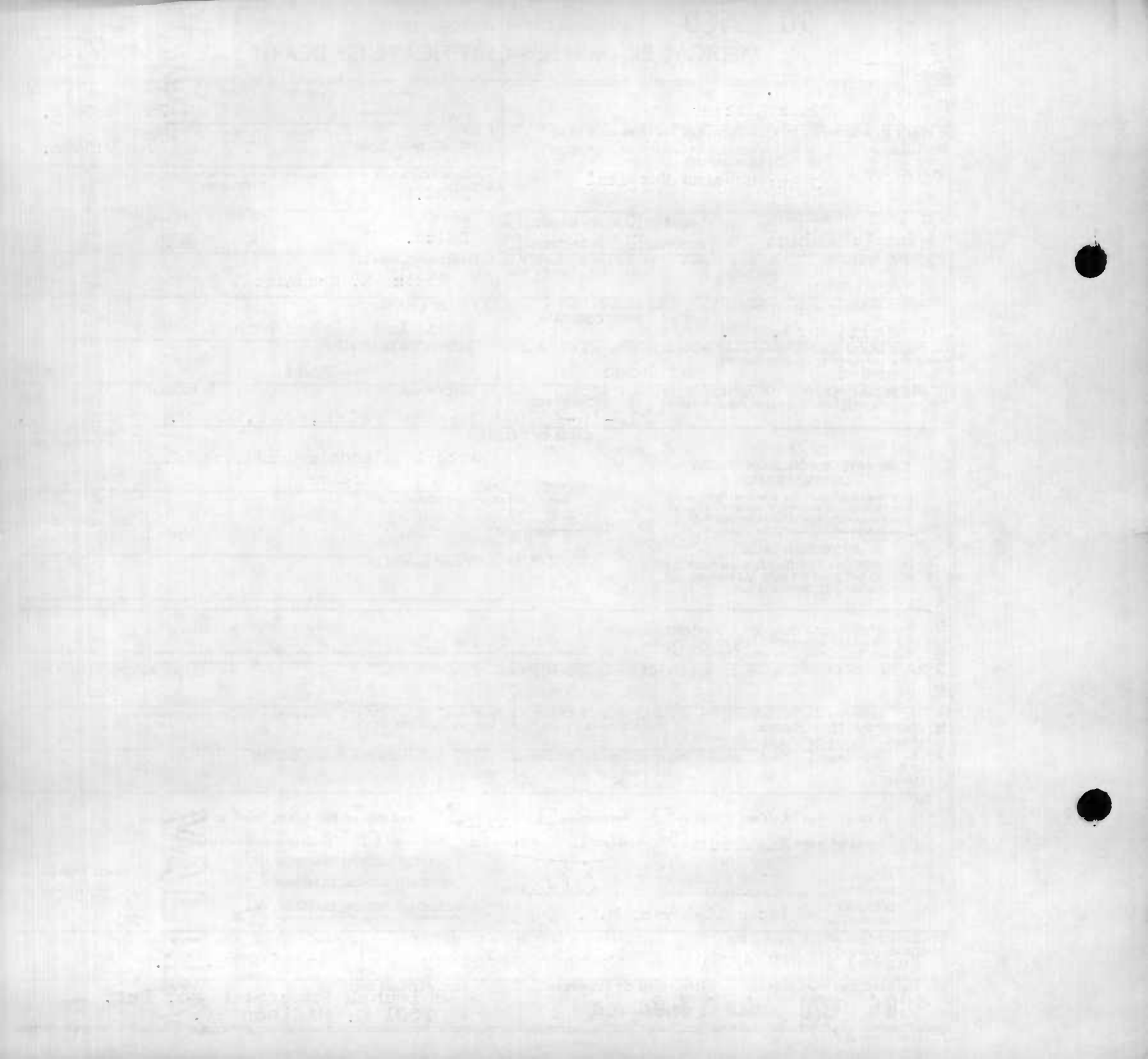
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7780

K-235
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Hilda Kistner		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 8 2 70 9:34 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year 8 2 70 9:34 a. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 702			
6. SEX female	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 12/2/1900
10. AGE (In years last birthday) 69		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Charles Richardson	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Poat	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 217-16-4576	
18. INFORMANT Marian Welsh, daught, 804 N. Kenwood Ave.		ADDRESS	
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8/3/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/6/70	
24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 2601 E. Madison St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

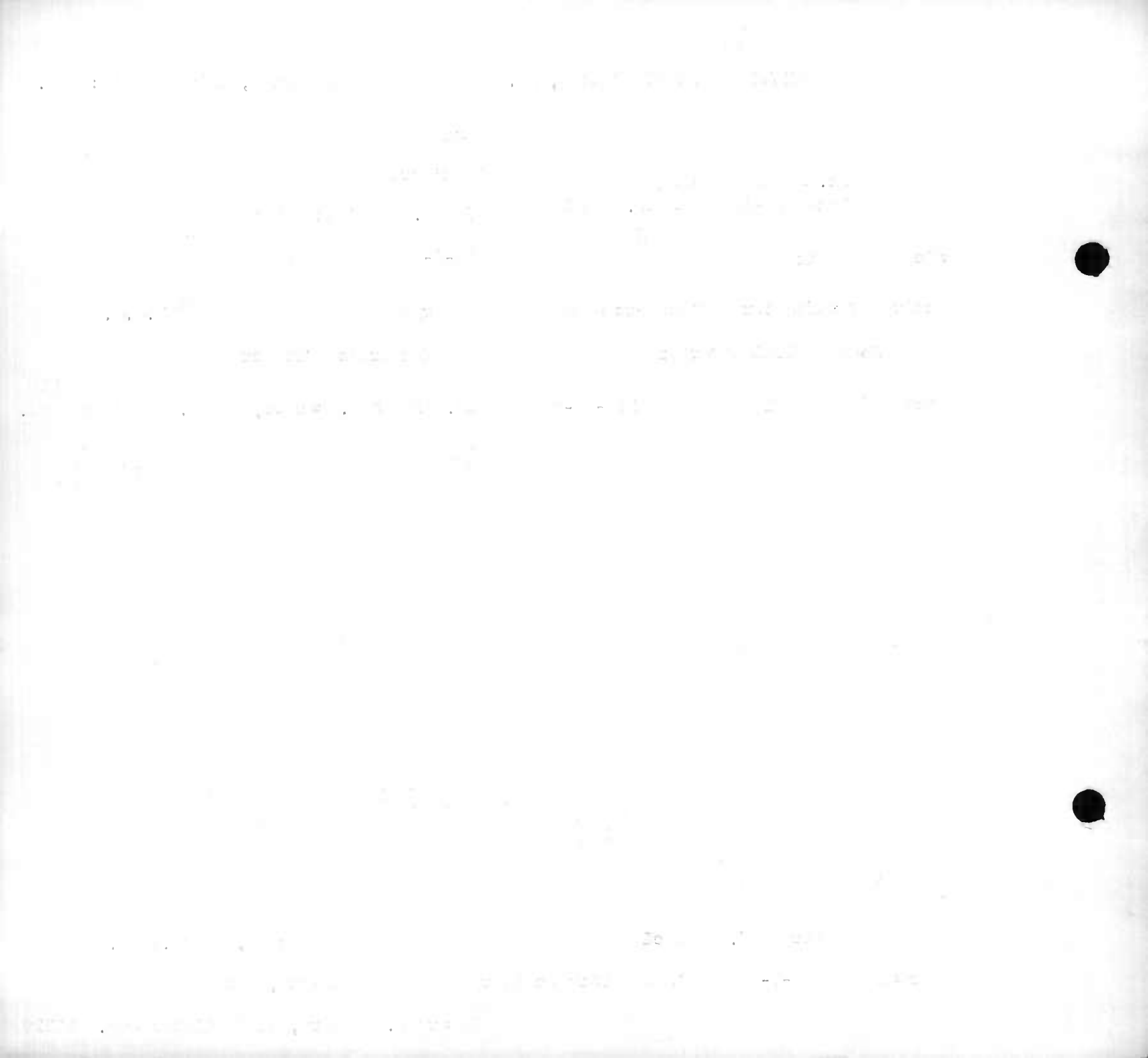
K-416		70 7781		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7781	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Josephine ROSE Keilbar (Keilbar)				2. DATE AND HOUR OF DEATH 7-31-70 10: 37 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland				Maryland 101			
5. SEX Female				6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-22-06 3-15-06		9. AGE (In years last birthday) 64		10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical				10B. KIND OF BUSINESS OR INDUSTRY Continental Can		11. BIRTHPLACE (State or foreign country) Baltimore Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John Keilbar			
14. MOTHER'S MAIDEN NAME Clara Loring				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 214-03-2417			
16. SOCIAL SECURITY NO. 214-03-2417				17. INFORMANT ADDRESS Reoords: Baltimore City Hospitals 4940 Eastern Avenue #21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Heat Stroke			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF: Hyperos malar Syndrome			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Cerebral Edema			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Pneumonia, Diabetes Mellitus			
19A. DATE OF OPERATION 7-26-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 931 Kenwood Ave 1-01		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 7-26-70 ?	
21E. INJURY OCCURRED While At Work		21F. HOW DID INJURY OCCUR? found unconscious by neighbor		22. I certify that (I) (this hospital) attended the deceased from 7/27 19 20 to 7/31 19 20 that (I) (we) last saw the deceased alive on 7/31 19 20 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Howard S. Goldberg M.D.				23B. DATE SIGNED 7/31/70		23C. PHYSICIAN'S NAME (Type) Howard S. Goldberg	
23D. ADDRESS Baltimore city Hospitals 4940 Eastern Avenue #21224				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 8/7/70		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) Baltimore, Md.		24E. STATE Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		25D. ADDRESS 3331 Brehms Lane	

Date of Birth Corrected by in. Z. office 9/9/70
Sedore Mihalakis, M.D.
SPB.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7782</u>
G-656 70 7782 CERTIFICATE OF DEATH		1. NAME OF DECEASED (Type or Print) WILLIAM HENRY GARMER, SR.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 40 St. Agnes Hospital Caton & Wilkens Aves. 21229		2. DATE AND HOUR OF DEATH August 4, 1970 11:30 A.		
5. SEX Male		6. RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-5-1900		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Firefighter		10B. KIND OF BUSINESS OR INDUSTRY Baltimore City		
13. FATHER'S NAME John William Garmer		14. MOTHER'S MAIDEN NAME Katherine Grenzer		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W I		16. SOCIAL SECURITY NO. 217-34-8084		
17. INFORMANT Mrs. Alvina K. Garmer, 743 S. Woodington Rd.		ADDRESS 21229		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I CAUSE OF DEATH acute coronary thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. MEDICAL CERTIFICATION		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 8-22-55 to 8-4-70 that (I) (we) lost saw the deceased alive on 7-7-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Harry S. Gimbel				23B. DATE SIGNED 8-5-70
23C. PHYSICIAN'S NAME (Type) Harry S. Gimbel				23D. ADDRESS 4605 Edmondson Avenue, Balto., Md.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-7-1970		
24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970		25B. NAME OF REGISTRAR Robert E. Barber, M.D.		
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS		



R-356

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7783

BIRTH NO. 69-18147

1. NAME OF DECEASED (Type or Print) ROBERT RITENOUR		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour August 4, 1970 2:57 P.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9-28-1969		10. AGE (In years last birthday) 10 7	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		15. MOTHER'S MAIDEN NAME Katherine Paul	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Mr. Dale R. Paul, 2114 Wilkens Ave.		ADDRESS 21223	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E 910.9		CAUSE OF DEATH Drowning	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Bathtub	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2114 Wilkens Avenue 2241 Ramsey St.		22F. HOW DID INJURY OCCUR? Drowned while in bathtub	
22D. TIME OF INJURY (APPROX.) 8-4-70 2:52 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 8/5/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-7-1970	
24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, Anne Arundel Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

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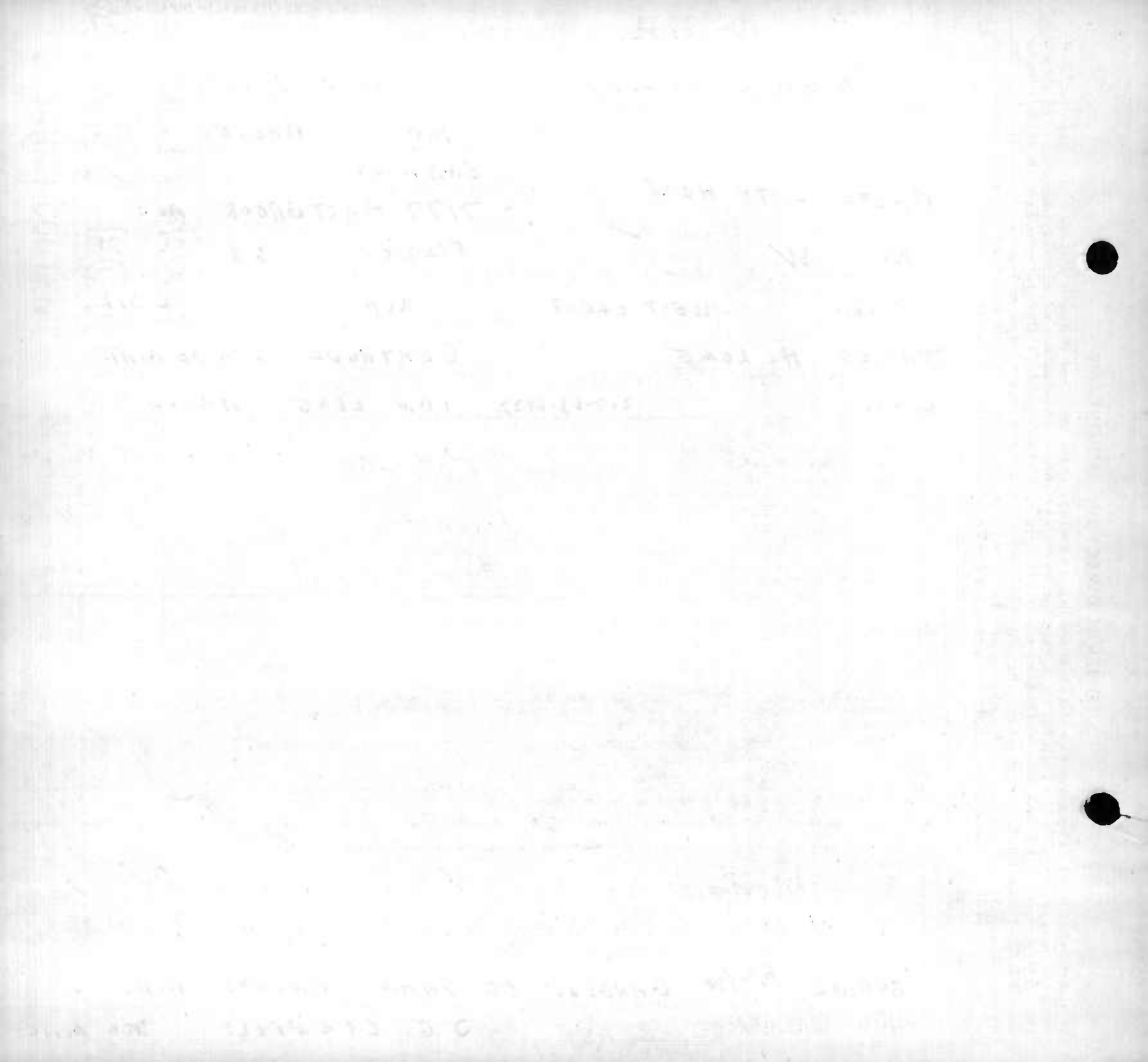
Paul M. Weiss

ROBERT H. RUBIN, 4107 WILSON AVE., CHICAGO, ILL. 60640
TEL. 733-4331, FAX 733-8328, WWW.CHICAGO.EDU

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-520 70 7784		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 7784	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) NORMAN L. LONG		2. DATE AND HOUR OF DEATH AUG. 1 1970 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO.		5.300	
FULL NAME OF HOSPITAL OR INSTITUTION BALTO. CITY HOSP.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN EAST POINT D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 5/29/07		9. AGE (In years last birthday) 63		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPA		10B. KIND OF BUSINESS OR INDUSTRY WEST. ELECT.		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES H. LONG		14. MOTHER'S MAIDEN NAME GERTRUDE LINDEMAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) VNK		16. SOCIAL SECURITY NO. 217-03-6927		17. INFORMANT ADDRESS 10A LONG ABOVE	
18. 250.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CORONARY Occlusion (B) Diabetes DUE TO, OR AS A CONSEQUENCE OF: (C) Hypertension		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 15 years 15 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 1938 to 1938 to June 19 70 , that (I) (we) last saw the deceased alive on June 30 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. No		23A. SIGNATURE Morris A. Jacobs DEGREE MD Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23B. DATE SIGNED 8/4/70		23C. PHYSICIAN'S NAME (Type) MORRIS A. JACOBS MD		23D. ADDRESS 1010 N. Point Road Balt 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/4/70		24C. NAME OF CEMETERY or CREMATORY GARDENS OF SAMM	
24D. LOCATION (City, town, or county) BALTO. MD.		25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970		25B. NAME OF REGISTRAR Robert E. Jaber, M.D.	
25C. FUNERAL DIRECTOR J.G. O'CONNELL		25D. ADDRESS 300 MACE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-100		70 7785		BALTIMORE CITY HEALTH DEPARTMENT		70 7785	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) SCHWAB LOUIS				2. DATE AND HOUR OF DEATH 8/4/70 at 1:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE				A. STATE B. COUNTY Md. 4009 Mortimer Ave. #152719			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4009 Mortimer Ave			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/13/36	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10B. KIND OF BUSINESS OR INDUSTRY Ins.?	11. BIRTHPLACE (State or foreign country) West Va		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Jacob				14. MOTHER'S MAIDEN NAME Sarah			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Hosp chart			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Irreversible shock				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Massive hemorrhage due to ruptured abdominal aneurysm							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 8/3/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal aneurysm		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/3 1970 to 8/4 1970 that (I) (we) last saw the deceased alive on 8/4 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Leveque GORR				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) LEVEQUE Hubert M.D.	
23D. ADDRESS Sinai Hospital of Baltimore		23E. DEGREE M.D.		23F. DEGREE M.D.		23G. DEGREE M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/70		24C. NAME OF CEMETERY OR CREMATORY Adath Jeshurun		24D. LOCATION (City, town, or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Sylvan Lewis & Son 9610 Reisterstown Rd		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

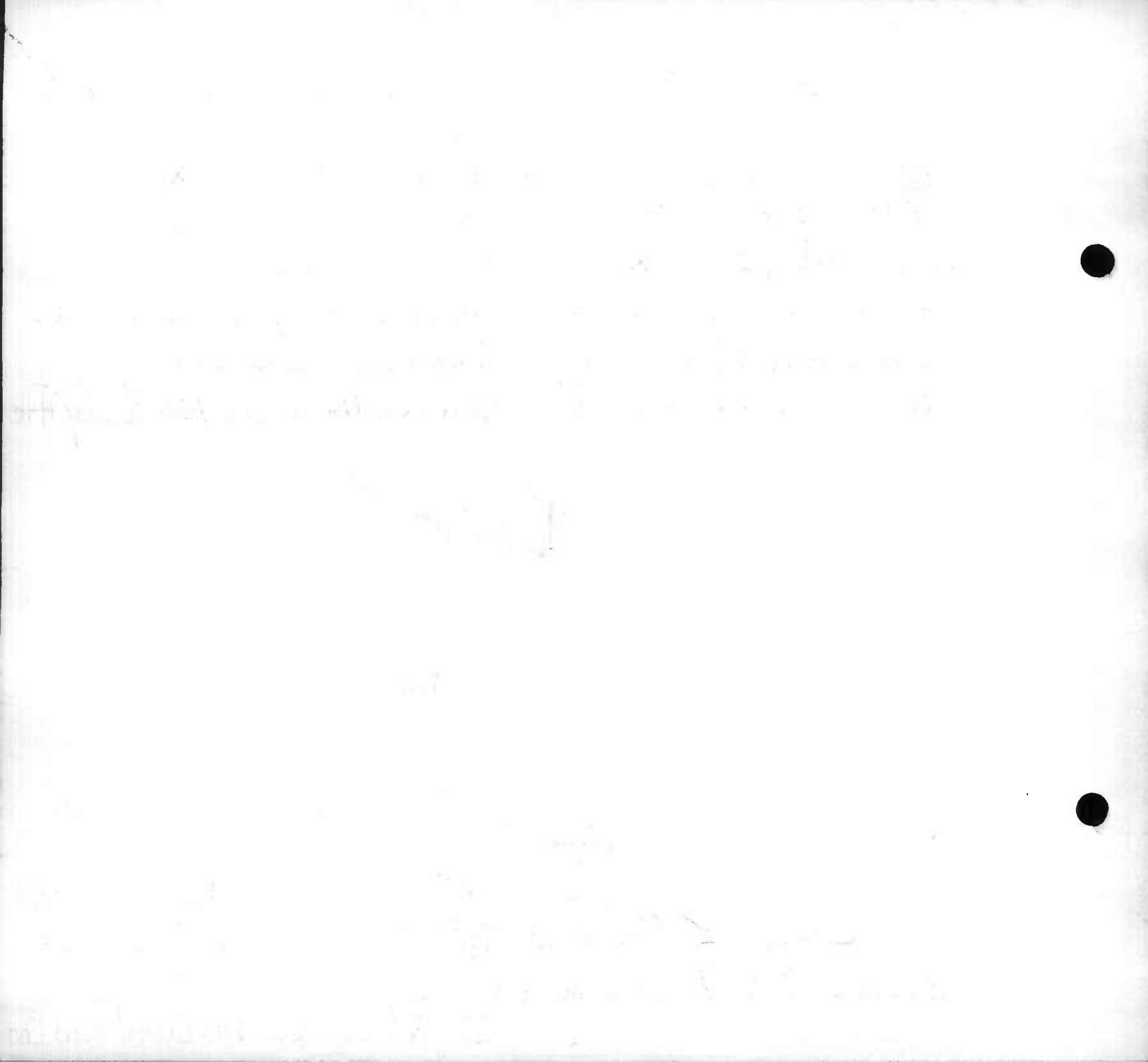
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7786	
M-635		70 7786		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Martin, Edna M.</i>		2. DATE AND HOUR OF DEATH <i>7/31/70 6:30 AM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital of Baltimore</i>		A. STATE <i>Baltimore City, Md.</i>		B. COUNTY <i>2719</i>	
		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>5802 Winne Ave.</i>			
5. SEX <i>Female</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/1/01</i>	9. AGE (in years last birthday) <i>69</i>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltim. Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Harry E. Edwards</i>			
14. MOTHER'S MAIDEN NAME <i>Lila Crusey</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO None</i>			
16. SOCIAL SECURITY NO. <i>705-05-6356</i>		17. INFORMANT <i>W. Robert L. Martin</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>427.01-13-7.0</i>		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Congestive heart failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i>	
		(B) <i>Unknown etiology</i> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Carcinoma of head of pancreas and biliary cirrhosis</i>					
19A. DATE OF OPERATION <i>7/23/70</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma of head of pancreas</i>		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>July 11</i> 19 <i>70</i> to <i>July 31</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>July 31</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <i>at 6:30 AM</i>					
23A. SIGNATURE <i>Albert M. Manner M.D.</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7/31/70</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <i>6215 A Pinch Rd., Baltimore, Md.</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>		<i>Aug 3, 1970</i>		<i>Windsor Hills Cemetery, Pikesville, Balt. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 6 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Frank H. Newell, Pikesville, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

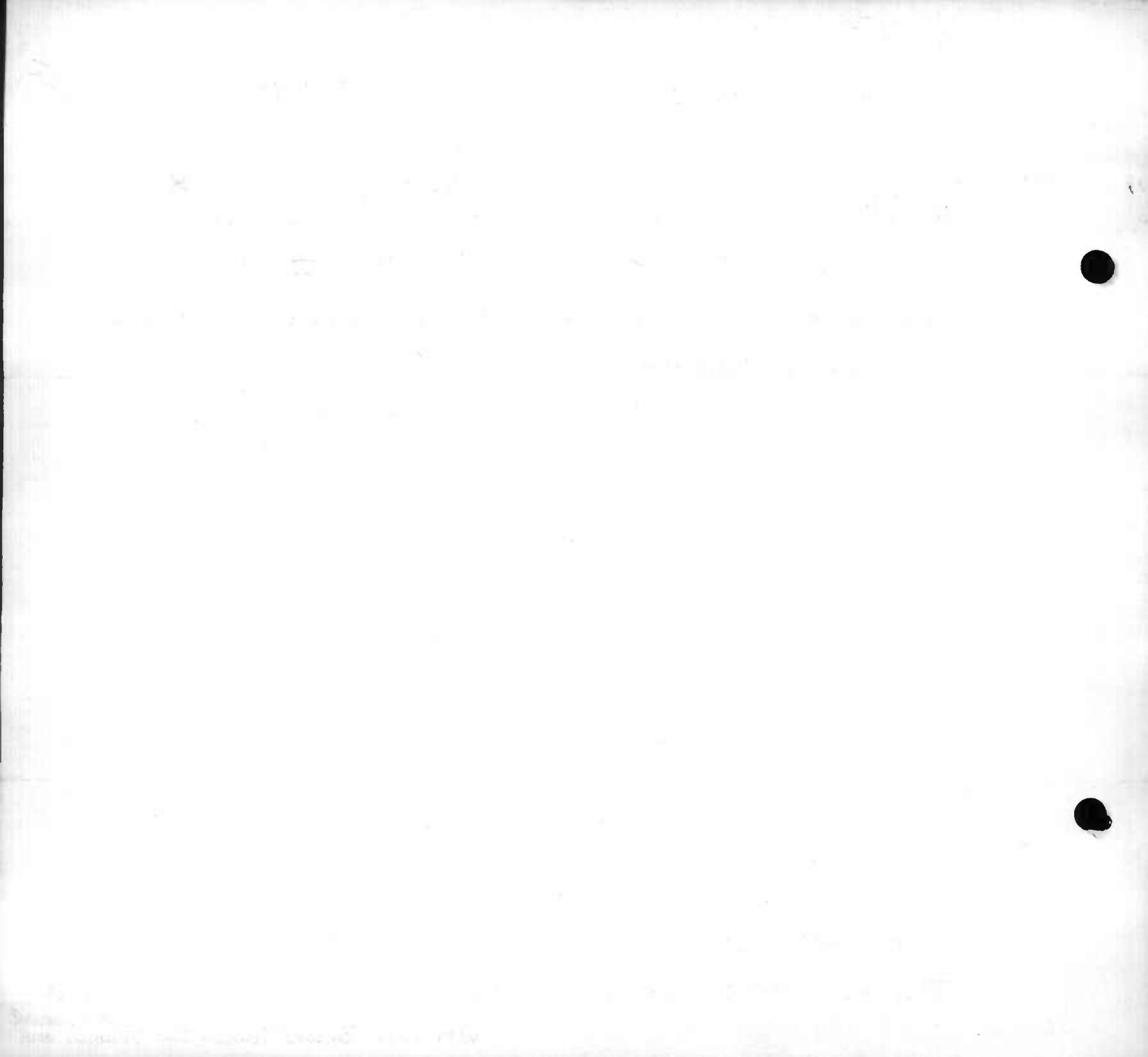
Baltimore City Health Department				REG. NO.	
N-242		70 7787		70 7787	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Emma L Nicholas		August 1, 1970 7:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Gould's Convalesarium		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
906116 Belair Road		E. STREET AND NUMBER		30 Sipple Avenue	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	6-20-95	75 yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
At Home		Housewife		Baltimore Maryland U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William Kuchling		Frances Green			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		313-52-8635		Walter Nicholas	
				ADDRESS 71236	
				7506 Kenney Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from June 1967 to Aug 1 1970 that (I) (we) last saw the deceased alive on July 19 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Charles C. MacMinn M.D.		August 3, 1970			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Charles C. MacMinn		2900 East Baltimore Street			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		8-4-1970		Baltimore Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 6 1970		Robert E. Farley, R.D.		Dippel Brothers 7110 Belair Road	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7788
H-553		70 7788		CERTIFICATE OF DEATH
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>BESSIE H. HAMMOND</u>		7-31-70 9 ¹⁵ / ₁₁ M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bolton Hill Nursing Home</u>		A. STATE <u>MD.</u> B. COUNTY <u>1101</u>		
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>1129 ST. PAUL ST. 21202</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-5-90</u>	9. AGE (In years last birthday) <u>79</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>
13. FATHER'S NAME <u>GEORGE WAGNER</u>		14. MOTHER'S MAIDEN NAME <u>?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-16-2001</u>		17. INFORMANT ADDRESS <u>Bolton Hill Nursing Home</u>
18. <u>412.41</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Fever of unknown etiology 1 day</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF:		
		(C) <u>Disease</u> DUE TO, OR AS A CONSEQUENCE OF:		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (This hospital) attended the deceased from <u>16 Dec 1968</u> to <u>31 July 1970</u> that (1) (we) last saw the deceased alive on <u>7/31 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>H. C. Alevizatos, M.D.</u>				23B. DATE SIGNED <u>7/31/70</u>
23C. PHYSICIAN'S NAME (Type) <u>H. C. ALEVIZATOS, M.D.</u>		23D. ADDRESS <u>1209 ST. PAUL ST.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>	<u>8-3-70</u>	<u>GARDENS OF FAITH</u>	<u>BALT. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 6 1970</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Towson, Inc. 1050 YORK RD. TOWSON, MD.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7789	
BIRTH NO. 8-163		70 7789		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Elizabeth C. Roberts			2. DATE AND HOUR OF DEATH July 30, 1970		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 901 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 723 Argonne Drive		
5. SEX Female	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1894	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Henry L. Thiemeyer		
14. MOTHER'S MAIDEN NAME Mary Kuebel			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. ?		17. INFORMANT Mr. Charles Roberts ADDRESS Same as # 4 E			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Cerebrovascular hemorrhage (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive arteriosclerotic (B) Vascular disease. DUE TO, OR AS A CONSEQUENCE OF: (C)		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-5 19 59 to 7-30 19 70, that (I) last saw the deceased alive on 1-30 19 70 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.					
23A. SIGNATURE Alfred G. Ossman, Jr.				23B. DATE SIGNED 8-1-70	
23C. PHYSICIAN'S NAME (Type) Alfred G. Ossman, Jr.				23D. ADDRESS 1101 St. Paul Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-3-70		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Memorial	
24D. LOCATION (City, town, or county) (State) Timonium Balt. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, Inc. Towson, Md.			

Small 18 1/2 inch

100 1/2 inch 10 1/2

6-2

8-2

12 1/2 1 1/2 1/2

14 1/2 1 1/2 1/2

16 1/2 1 1/2 1/2

18 1/2 1 1/2 1/2

20 1/2 1 1/2 1/2

22 1/2 1 1/2 1/2

24 1/2 1 1/2 1/2

26 1/2 1 1/2 1/2

28 1/2 1 1/2 1/2

30 1/2 1 1/2 1/2

32 1/2 1 1/2 1/2

34 1/2 1 1/2 1/2

36 1/2 1 1/2 1/2

38 1/2 1 1/2 1/2

40 1/2 1 1/2 1/2

42 1/2 1 1/2 1/2

44 1/2 1 1/2 1/2

46 1/2 1 1/2 1/2

FUNERAL DIRECTOR: IMPORTANT

MEDICAL EXAMINER'S OFFICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-652 70 7790 BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 70 7790	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Bernstein, Harry</u>		2. DATE AND HOUR OF DEATH <u>8-1-70</u> <u>12³⁰</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 JOHNS HOPKINS HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>	
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>06-05-10</u>		9. AGE (In years last birthday) <u>60</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>DAVIS BERNSTEIN</u>	
14. MOTHER'S MAIDEN NAME <u>SARA ROSENSTERN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-03-1573</u>	
17. INFORMANT <u>Mrs Irene Bernstein - Same</u>		ADDRESS		18. CAUSE OF DEATH <u>410.9 I</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>INFERIOR-POST MT</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from <u>8-1</u> 19 <u>70</u> to <u>8-1</u> 19 <u>70</u> that we (we) last saw the deceased alive on <u>8-1</u> 19 <u>70</u> and that in our (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) not view the body after death.					
23A. SIGNATURE <u>Anthony J. Jackson</u>		23B. DATE SIGNED <u>8-1-70</u>		23C. PHYSICIAN'S NAME (Type) <u>ANTHONY JACKSON</u>	
23D. ADDRESS <u>MEDICAL INTERN, JOHNS HOPKINS HOSP</u>		23E. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		23F. ADDRESS <u>6010 Relat Rd.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/2/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Maryland Lodge</u>	
24D. LOCATION <u>Balto, Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>AUG 6 1970</u>		24F. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	
24G. FUNERAL DIRECTOR <u>Vol. Turner & Bros. Inc.</u>		24H. ADDRESS		24I. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
70 7791 CERTIFICATE OF DEATH					REG. NO. 70 7791									
BIRTH NO. <u>K-162</u>					1. NAME OF DECEASED (Type or Print) <u>RIVERS, NETTIE</u>					2. DATE AND HOUR OF DEATH <u>Aug 1, 1970</u> <u>3:58 A M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2831</u>									
FULL NAME OF HOSPITAL OR INSTITUTION <u>12 SINAI HOSPITAL OF BALTIMORE</u> <u>42 BELVEDERE AVE AT GREENPARK</u> <u>BALTIMORE, MARYLAND</u>					C. CITY OR TOWN <u>BALTIMORE</u>					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
5. SEX <u>FEMALE</u>					6. RACE <u>WHITE</u>					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>					8. DATE OF BIRTH <u>XXXXXX</u> <u>1900</u>				
										9. AGE (In years last birthday) <u>70</u>				
										11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>				
										12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>ITZKE MELNIKOFF</u>					14. MOTHER'S MAIDEN NAME <u>SARAH</u>					17. INFORMANT <u>MR. ISRAEL RIVERS, 6612 VINCENT LANE</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO.					ADDRESS <u>APT. 202</u>				
18. <u>4109 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction with</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Longtime heart failure & hypothyroidism</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>About one month</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).														
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <u>no</u>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>July 27/70</u> 19 <u>70</u> to <u>Aug 1</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>Aug 1</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <u>Linda Jan</u> <u>DR. EDWARD KALLINS</u>										23B. DATE SIGNED <u>Aug 1, 1970</u>				
23C. PHYSICIAN'S NAME (Type) <u>DR. EDWARD KALLINS</u>										23D. ADDRESS <u>SINAI HOSPITAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>					24B. DATE <u>8-2-70</u>					24C. NAME of CEMETERY or CREMATORY <u>BNAI JACOB</u>				
										24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 6 1970</u>					25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD</u>					25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN RD.</u>				



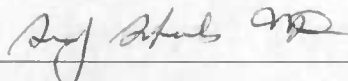
FUNERAL DIRECTOR: IMPORTANT

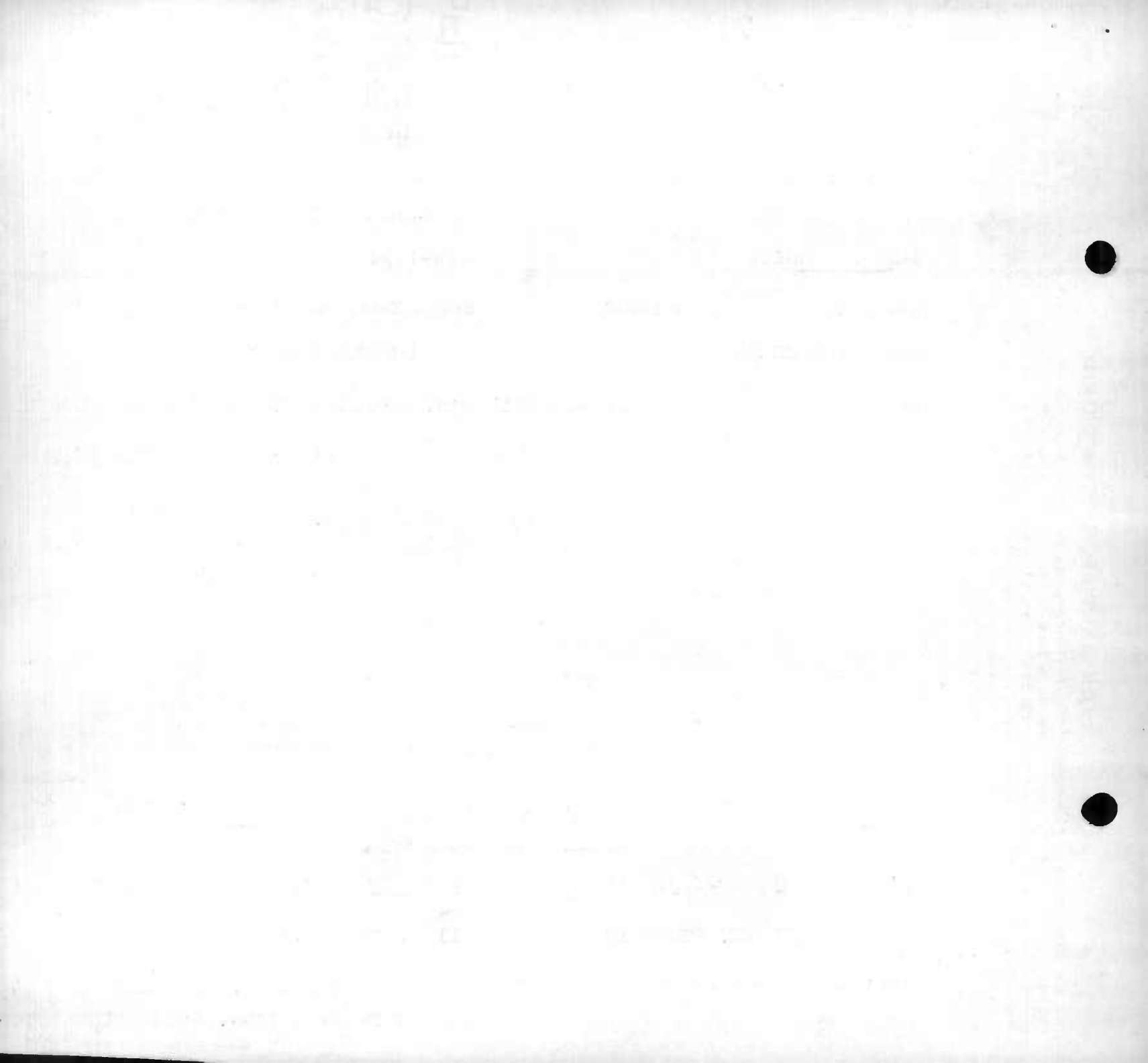
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 7792</u>	
BIRTH NO. <u>C-500</u>		70 7792	
1. NAME OF DECEASED (Type or Print) <u>COHEN, GERTRUDE</u>		2. DATE AND HOUR OF DEATH <u>8/2/70</u> <u>4:15 AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSP. OF BALTO., INC.</u>		A. STATE <u>MARYLAND</u> , B. COUNTY <u>BALTO.</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>42</u>		E. STREET AND NUMBER <u>3318 CLARKS LANE #15</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/21/03</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EMPLOYEE</u>		9. AGE (in years last birthday) <u>66</u>	11. BIRTH PLACE (State or foreign country) <u>BALTO. MARYLAND</u>
10B. KIND OF BUSINESS OR INDUSTRY <u>XXXXXX</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>COHEN, WOLF</u>		14. MOTHER'S MAIDEN NAME <u>HANNAH BASS</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>215-22-2666</u>	
17. INFORMANT <u>RELIA F. SINGER</u>		ADDRESS <u>3318 CLARKS LANE #15</u>	
18. <u>4/10/91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <u>MYOCARDIAL INFARCTION</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>14-15 hrs.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>-</u> DUE TO, OR AS A CONSEQUENCE OF:	
(C) <u>-</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>NO</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 1, 1970</u> to <u>AUGUST 2, 1970</u> that (I) (we) last saw the deceased alive on <u>4:15 AM 8/2/1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.			
23A. SIGNATURE <u>Vichai Atichartakarn, M.D.</u>		23B. DATE SIGNED <u>8/2/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>VICHAJ ATICHARTAKARN, M.D.</u>		23D. ADDRESS <u>SINAI HOSP. OF BALTO., INC.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>8-3-70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>OHEL YAKOV</u>	24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 6 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	25C. FUNERAL DIRECTOR <u>SOE LEVINSON & BROS., 6010 REISTERSTOWN RD.</u>

FUNERAL DIRECTOR: IMPORTANT

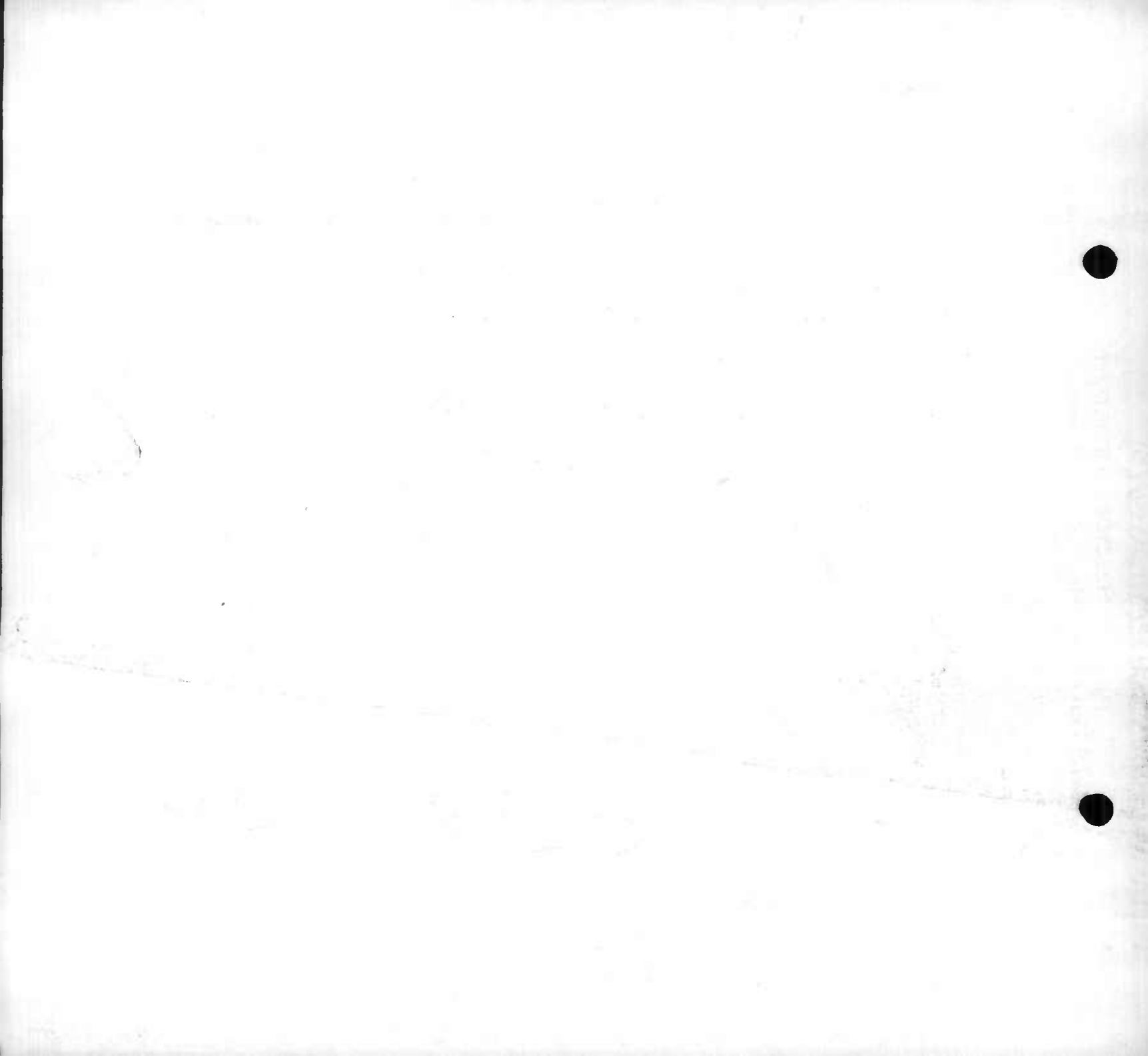
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO.		70 7793	
T-125 70 7793 CERTIFICATE OF DEATH							
BIRTH NO. 1. NAME OF DECEASED (Type or Print) IRVIN AARON TABACKMAN				2. DATE AND HOUR OF DEATH AUGUST 2, 1970 10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITAL 31				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND Baltimore C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2308 FARRINGDON ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-20-1924	9. AGE (In years lost birthday) 46	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY PRODUCE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRY TABACKMAN			14. MOTHER'S MAIDEN NAME REBECCA LANDSBERG				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-10-8615		17. INFORMANT MRS. GOLDIE LEVY, 2308 FARRINGDON RD ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 4-10-91 CAUSE OF DEATH Acute myocardial infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Atherosclerotic CVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 3 1/2 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 19		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 11		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 11		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 11			
21D. TIME OF INJURY (APPROX.) 11		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 11			
22. I certify that (I) (this hospital) attended the deceased from 11-30 1967 to 5-13 1970 , that (I) (we) last saw the deceased alive on 5-13 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-3-70	
23C. PHYSICIAN'S NAME (Type) SIDNEY SCHERLIS				23D. ADDRESS 11 E. CHASE STREET			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-4-70		24C. NAME OF CEMETERY or CREMATORY SHOMREI HADATH		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970		25B. NAME OF REGISTRAR Robert E. Fabel		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400		70 7794		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7794	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) GEORGE E. BALL			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 8/3/70 6:40 PM.			
FULL NAME OF HOSPITAL OR INSTITUTION NORTH CHARLES GENERAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX MALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				E. STREET AND NUMBER 102 S. Schroeder ST			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				8. DATE OF BIRTH 03-31-13 9. AGE (In years last birthday) 57			
10B. KIND OF BUSINESS OR INDUSTRY Caroline Laundry				11. BIRTHPLACE (State or foreign country) Burgundy			
13. FATHER'S NAME CONRAD S BALL				12. CITIZEN OF WHAT COUNTRY? U.S.A			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Yes If yes, give war or dates of service 70				14. MOTHER'S MAIDEN NAME BESSIE KIRK			
16. SOCIAL SECURITY NO. 224-09-3765				17. INFORMANT William Dwyer - 1010 W. Lombard St			
18. 444.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PERITONITIS			
ANTECEDENT CAUSES				(B) MESENTERIC VEIN THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 6-17-70				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ESOPHAGEAL OBSTRUCTION		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 8/3/70 19 to 8/3/70 19 that (I) (we) lost saw the deceased alive on 8/3 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Teodoro R. Carangal				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/4/70	
23C. PHYSICIAN'S NAME (Type) TEODORO R CARANGAL				23D. ADDRESS NORTH CHARLES GENERAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/70		24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR John J. Bowman & Son Inc.		ADDRESS 901 Hollins St.	



FUNERAL DIRECTOR: IMPORTANT

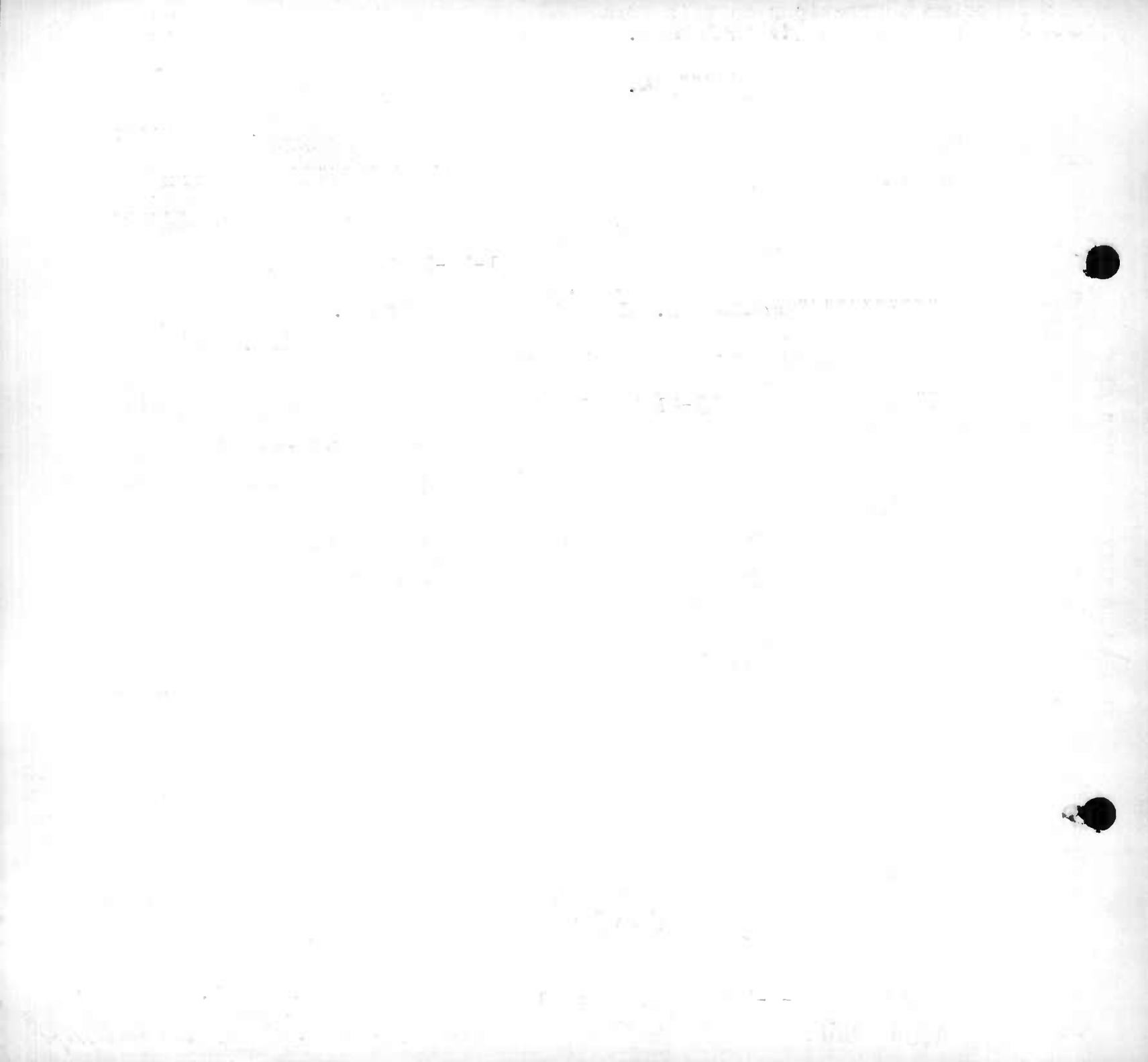
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7795	
BIRTH NO. H-561		70 7795 CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH Aug. 3, 1970	
1. NAME OF DECEASED (Type or Print) CHARLES C. HAMMERBACKER Sr.			3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2505		
5. SEX Male			6. RACE WHITE		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Jan. 13, 1912		
9. AGE (In years lost birthday) 58			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME George Hammerbacker			14. MOTHER'S MAIDEN NAME Mary Baker		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213 03 6047		
17. INFORMANT Family			ADDRESS Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Arteriosclerosis Heart Disease DUE TO, OR AS A CONSEQUENCE OF:		
(C) Diabetes Mellitus			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1965		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/20 19 7/20 1970 that (I) (we) lost saw the deceased alive on 7/20 19 7/20 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William A. Simon				23B. DATE SIGNED 8/3/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/6/70		24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery	
24D. LOCATION (City, town, or county) (State) Balto. 21225		25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR John H. Hahn 4200 Pennington Ave. (26)			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
REG. NO. 70 7796									
<div style="display: flex; justify-content: space-between;"> <div> <p>The corrections on this form were made by 70 7796 70 7796</p> </div> <div> <p>X</p> </div> </div>									
1. NAME OF DECEASED (Type or Print) RALPH (####) ANSTINE					2. DATE AND HOUR OF DEATH JUGUST 3 1970				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION NORTH CHARLES GENERAL HOSPITAL					A. STATE MARYLAND B. COUNTY BALTIMORE				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN DUNDALK D. INSIDE CITY LIMITS? XXXX NO <input checked="" type="checkbox"/>				
E. STREET AND NUMBER 1413 VESTER AVE., DUNDALK Md									
5. SEX MALE	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1-28-1901	9. AGE (In years last birthday) 69	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Op. Electric		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME HARRY ANSTINE		14. MOTHER'S MAIDEN NAME LIZ. (?)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO YES *****1921-26			16. SOCIAL SECURITY NO. 217035507		
17. INFORMANT J. PAPASTEPHANOU, North Charles Gen.			ADDRESS						
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Acute Myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Shock, Diabetes Mellitus (B) Heart Failure (C) -					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 3				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION 8-7-1970			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/30 19 70 to 8/3 19 70 that (I) (we) lost saw the deceased alive on 8/3 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. Papastephanou					23B. DATE SIGNED 8/3/70			23C. PHYSICIAN'S NAME (Type) J. PAPASTEPHANOU	
23D. ADDRESS North Charles Gen. Hospital									
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE 8-7-1970			24C. NAME OF CEMETERY or CREMATORY Free Gospel			24D. LOCATION (City, town, or county) (State) CRALEY, PENNA.
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970			25B. NAME OF REGISTRAR Robert E. Fisher, M.D.			25C. FUNERAL DIRECTOR Walter Brooks Bradley Inc.			ADDRESS Dundalk, Md



FUNERAL DIRECTOR: IMPORTANT

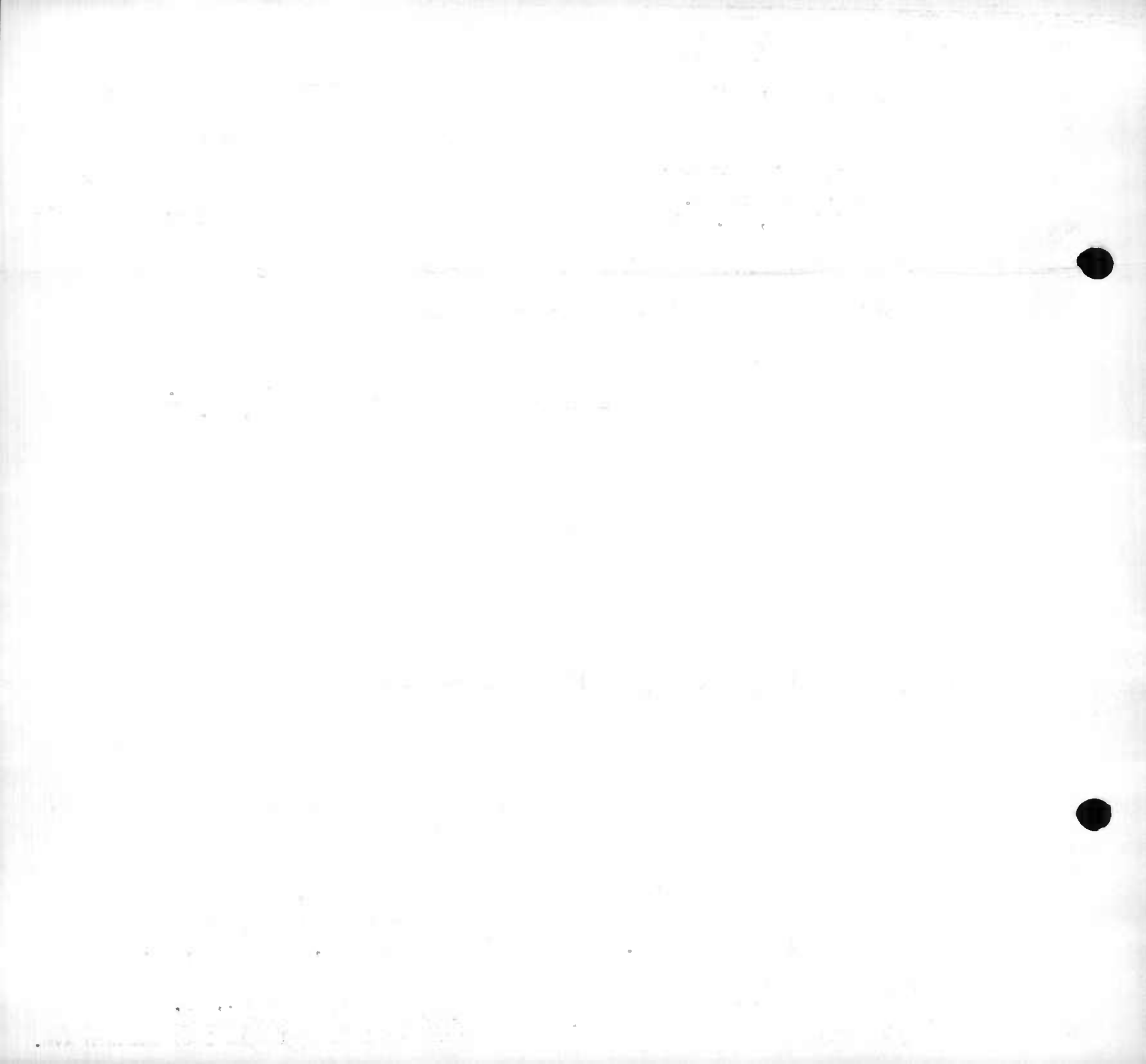
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <u>70 7797</u>	
BIRTH NO. <u>A-450</u>		70 7797		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Judge JOSEPH ALLEN</u>			2. DATE AND HOUR OF DEATH <u>July 28, 1970 5:45 PM</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2730</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE</u> <u>42 BELVEDERE AVENUE AT GREENSPRING</u> <u>BALTIMORE, MARYLAND</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>MALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>3/5/1895</u>		9. AGE (in years last birthday) <u>75</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTORNEY</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>AT LAW</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK CITY</u>
13. FATHER'S NAME <u>HARRIS ALLEN</u>			14. MOTHER'S MAIDEN NAME <u>KUHNE KILBASHINSKY</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>218-36-8679</u>		17. INFORMANT <u>MR. ROBERT SKUTCH, JR., c/o WEINBERG & GREEN</u>
18. <u>571.81</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Liver failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Post necrotic cirrhosis</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>7/14</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>liver</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/14</u> 19 <u>70</u> to <u>July 28</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>July 28</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>L. Tan</u>			23B. DATE SIGNED <u>July 28, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>LINDA TAN</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>7-30-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BETH EL MEMORIAL PARK</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 6 1970</u>			25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN</u>

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. S-200		70 7798		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 7798	
1. NAME OF DECEASED (Type or Print) Susi, Antonio				2. DATE AND HOUR OF DEATH 8-3-70 8:30 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224				A. STATE Maryland B. COUNTY Baltimore			
				C. CITY OR TOWN Essex		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 48 A Fenway South 21221 005			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-4-85	9. AGE (In years last birthday) 85	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10B. KIND OF BUSINESS OR INDUSTRY Painting Contractor		11. BIRTHPLACE (State or foreign country) Euro Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Pasquale Susi				14. MOTHER'S MAIDEN NAME Rosa ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-16-6498		17. INFORMANT BCH Records: 4940 Eastern Ave. Baltimore, Md. 21224			
18. 7-28-X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CAUSE OF DEATH <i>Congestive heart failure</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Heart Insufficiency + Azotemia</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)..... ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 1957		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Prostatectomy</i>		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-72 19 70 to 8-3 19 70 that (I) (we) last saw the deceased alive on 8-3 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Michel Saade</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8-3-70	
23C. PHYSICIAN'S NAME (Type) Michel Saade Md.				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave., Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/6/70		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR <i>Bruzdzinski</i> ADDRESS Bruzdzinski Funeral Home 1407 Eastern Ave.			



1

N-200

70

7799

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7799

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Edwine Nash		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> 8 4 70 8:00 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1613 N. Montford Ave.		3. DATE PRONOUNCED DEAD Month Day Year 8 4 70 8:00 a.m.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Feb. 18, 1934		10. AGE (In years lost birthday) 36	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Estelle Wilkens		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 219-28-7538		18. INFORMANT Morris Nash Sr.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty alteration of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Sickle cell disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type): Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 8/4/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/70	
24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970		25B. NAME OF REGISTRAR Robert E. Jaben, M.D.	
25C. FUNERAL DIRECTOR Kelson F.H.		25D. ADDRESS 1348 N. Calhoun St.	

ACADEMY BOND

1000 DOLLARS

VALLEY PARK CO

U.S.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7800	
CERTIFICATE OF DEATH					
BIRTH NO. 11-506		70 7800			
1. NAME OF DECEASED (Type or Print) Unger, Lillian Severna			2. DATE AND HOUR OF DEATH 8-4-70 3⁵⁹ M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hospital 44			A. STATE Maryland B. COUNTY 1802		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 201 N. Carey St.		
5. SEX F.	6. RACE N.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06-07-02	9. AGE (in years last birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME James Smith			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Chart.
			ADDRESS Balto. Md. #18		
18. 188X I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Terminal carcinoma of urinary bladder.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-3 19 70 to 8-4 19 70 that (I) (we) last saw the deceased alive on 8-4 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE K. Bum Lee M.D.				23B. DATE SIGNED 8-4-1970	
23C. PHYSICIAN'S NAME (Type) K. Bum Lee M.D.				23D. ADDRESS Union Mem. Hospital Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/8/70		Arbutus Mem. Park	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970		25B. NAME OF REGISTRAR J. E. V. V. V. V.		25C. FUNERAL DIRECTOR Kelson F.H.	
				ADDRESS 1348 N. Calhoun St.	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-000 70 7801		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7801	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) KIAH, ARTHUR		2. DATE AND HOUR OF DEATH AUGUST 2, 1970 10:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOUSE IN THE PINES BELVEDERE 2525 WEST BELVEDERE AVENUE BALTIMORE, MARYLAND 21215		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY BALTIMORE, MARYLAND 1802		C. CITY OR TOWN BALTIMORE	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11-6-26		9. AGE (In years last birthday) 41		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Arthur Kiah		14. MOTHER'S MAIDEN NAME Edna John	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W. II		16. SOCIAL SECURITY NO. 217-20-9608		17. INFORMANT Bernice Vaughn 1811 Dukeland St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DEHYDRATION CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: C A of Oral Cavity ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 6 months			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/11 1970 to 8/2 1970 that (I) (we) last saw the deceased alive on 8/2 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alan Cohen		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) ALAN COHEN M.D.	
23D. ADDRESS MARYLANDER APARTMENTS BALTIMORE, MARYLAND		23E. DEGREE		23F. ADDRESS BALTIMORE, MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/6/70		24C. NAME of CEMETERY or CREMATORY Loudon Park Nat'l Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. AUG 6 1970		24F. NAME OF REGISTRAR Robert E. Bailey	
24G. FUNERAL DIRECTOR Kelson F.H.		24H. ADDRESS 1348 N. Calhoun St.		24I. NAME OF REGISTRAR Robert E. Bailey	

2000-10-10
2000-10-10

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2000-10-10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 7802		REG. NO. 70 7802	
BIRTH NO. <u>T-660</u>				1. NAME OF DECEASED (Type or Print) <u>ESSIE THROWER</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <u>AUGUST 4, 1970 2:00 P.M.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>16 LUTHERAN</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1607</u>		C. CITY OR TOWN <u>BALTO.</u>	
5. SEX <u>F</u>		6. RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-06-98</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) <u>71</u>		11. BIRTHPLACE (State or foreign country) <u>Ayden, North Carolina</u>	
13. FATHER'S NAME <u>Ed Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Cassie Smith</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-20-5454</u>		17. INFORMANT ADDRESS <u>Doris Johnson 1423 Mosher St.</u>			
18. <u>25091</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>UNCONTROLLED DIABETES</u>				<u>YEARS</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CEREBROVASCULAR ACCIDENT</u>				<u>DAYS</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Shaw negative Septicemia & Shock</u>				<u>5 days</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>he</u> (this hospital) attended the deceased from <u>JULY 25, 1970</u> to <u>AUGUST 4, 1970</u> that <u>he</u> (we) last saw the deceased alive on <u>AUGUST 4, 1970</u> and that <u>in my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>we</u> (We) (did) <u>not</u> view the body after death.							
23A. SIGNATURE <u>Christos Dibranos, M.D.</u>				23B. DATE SIGNED <u>8.4.1970</u>		23C. PHYSICIAN'S NAME (Type) <u>CHRISTOS DIBRANOS, M.D.</u>	
23D. ADDRESS <u>730 ASHBURTON ST., BALTO., MD. 21216</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>8/8/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Carver Mem. Pk.</u>		24D. LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 6 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Kelson F.H. 1348 N. Calhoun St.</u>			

15

BIRTH NO.		70 7803		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 7803	
1. NAME OF DECEASED (Type or Print) FRANK L. NELSON				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3804 Greenmount Ave.				3. DATE PRONOUNCED DEAD Month Day Year Hour 8 1 1970 2:45 P.M.		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE MD. B. COUNTY 1201			
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH April 25, 1913		10. AGE (in years last birthday) 57		11. BIRTHPLACE (State or foreign country) Savannah, Ga.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George L. Nelson	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter		14B. KIND OF BUSINESS OR INDUSTRY Jefferson Auning Co.		15. MOTHER'S MAIDEN NAME Clara Nokes					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes		17. SOCIAL SECURITY NO. 218-07-3870		18. INFORMANT Frank G. Nelson - 6213 Pilgrim Rd. - 21214		ADDRESS			
19. 319, 21-0971 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Cor pulmonale DUE TO, OR AS A CONSEQUENCE OF: (B) chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-2-70									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-6-70		24C. NAME OF CEMETERY or CREMATORY BELAIR MEMORIAL GARDENS		24D. LOCATION (City, town, or county) (State) BELAIR, MD.			
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206		ADDRESS			

John M.

London National (London)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

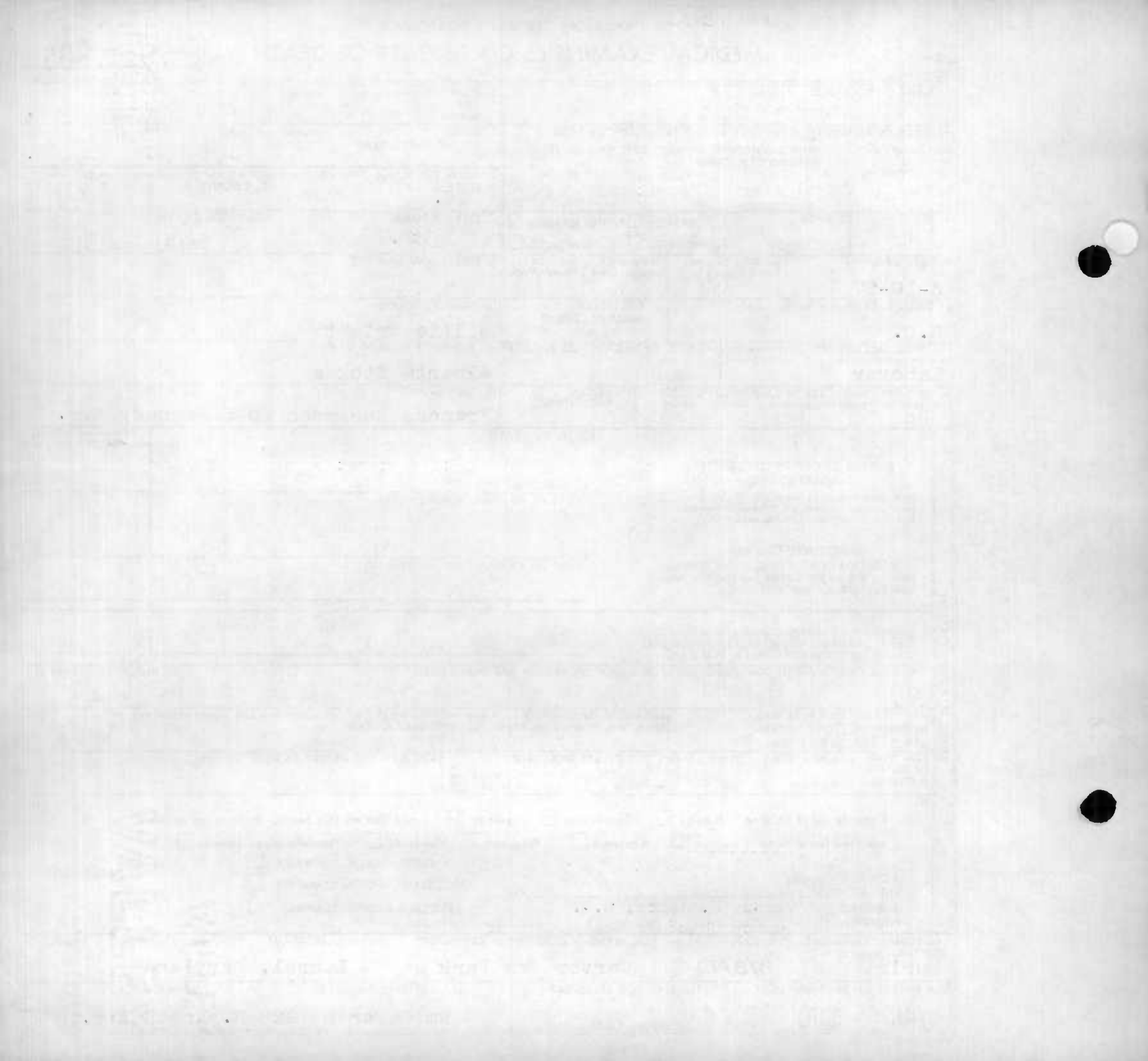
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7804	
H-250		70 7804		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Loretta Hogan		8/3/70	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 4513 Old Frederick Road Apt A		A. STATE		B. COUNTY	
		Md			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		4513 Old Frederick Road Apt A			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
female	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8/15/1897	72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired				Maryland	
12. CITIZEN OF WHAT COUNTRY?		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Michael Hogan		Ann Miller			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		214-38-4528		Mrs. Helen Hartge, 4908 Allson Drive	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		<i>Cerebral Hemorrhage</i>	
		(B) A.S.C.V.D DUE TO, OR AS A CONSEQUENCE OF:		<i>years</i>	
		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1965 to Aug 3 1970, that (I) (we) last saw the deceased alive on July 29 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
<i>J. C. Pound</i>		8/4/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. J. C. Pound		3325 Frederick Road			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	8/6/70	New Cathedral Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 6 1970		Robert E. Jarboe, M.D.		Witzke, 4101 Edmondson Avenue	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7805

BIRTH NO.

1. NAME OF DECEASED (Type or Print) George Wright		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> 8 3 70 Month Day Year		Hour 3:45 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD 8 3 70 Month Day Year		Hour 3:45 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 708		6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 3-10-27		10. AGE (In years lost birthday) 43		11. BIRTHPLACE (State or foreign country) S.C.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Willie Wright		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Alberta Stokes		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Frances Robinson		19. CAUSE OF DEATH 571.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Fatty alteration of the liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/4/70					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/70		24C. NAME OF CEMETERY OR CREMATORY Carver Mem Park	
24D. LOCATION (City, town, or county) Laurel, Maryland		24E. STATE (State) Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970	
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Wm C March		25D. ADDRESS 928 E. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-606		70 7806		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7806	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Frye, (Geraldine) Edith G.</u>				2. DATE AND HOUR OF DEATH <u>Aug 4, 1970</u> <u>12:30 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <u>Md.</u>		B. COUNTY <u>Baltimore</u>	
5. SEX <u>F</u>		6. RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/22/24</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Frye</u>				14. MOTHER'S MAIDEN NAME <u>Mary</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Older + Elise Frye</u>		ADDRESS	
18. <u>571.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Probable aspiration</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>termina</u>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Laenec's Cirrhosis, Ascites</u>				DUE TO, OR AS A CONSEQUENCE OF: <u>years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Myocardopathy</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>July 22, 1970</u> to <u>Aug 4, 1970</u> that (I) (we) last saw the deceased alive on <u>Aug 4, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Peter Densen</u>				23B. DATE SIGNED <u>Aug 4, 1970</u>			
23C. PHYSICIAN'S NAME (Type) <u>Peter Densen MD</u>				23D. ADDRESS <u>601 M. Broadway; Balto. Md</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-10-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Anne Arundel City Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 6 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>WM M.A. RCH</u>		ADDRESS <u>928 E 14th Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-325		700 7807		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO.		70 7807	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Russell J. Watson Sr</u>				2. DATE AND HOUR OF DEATH <u>8/4/70</u> <u>5:45 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO.</u>				5. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4 UNION MEMORIAL</u>				E. STREET AND NUMBER <u>404 Westline Road</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/11/08</u>	9. AGE (in years last birthday) <u>62</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. POST OFFICE</u>			11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John N. Watson</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET Russell</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>213 10 8431</u>		17. INFORMANT <u>Wife</u>		ADDRESS <u>SOME</u>		
18. <u>44191</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIAC arrest.</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>renal failure (acute)</u>					
				(C) <u>post op. abd. aortic aneurism</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <u>37/30/70</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Fair to good</u>			20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR			
22. I certify that (I) (this hospital) attended the deceased from <u>7/26</u> 19 <u>70</u> to <u>8/4</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>8/4</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>[Signature]</u> <u>M.D.</u> DEGREE						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/4/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Carlton E. Fossi</u> <u>M.D.</u> DEGREE			23D. ADDRESS <u>UNION MEMORIAL Hospital</u>						
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8-7-70</u>		24C. NAME of CEMETERY or CREMATORY <u>WOODLAWN CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 6 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR, ADDRESS <u>WEBER FUNERAL HOME 5311 EDMONDSON AVE</u>					



G-200

70

7808

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70

7808

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LOUIS GOS		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour AUG 4 70 ? M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2601 Fait Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour August 4, 1970 6:35 P. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 104			
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 4-8-1906	10. AGE (in years last birthday) 63	11. BIRTHPLACE (State or foreign country) POLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ALEXANDER GOS	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMEN		15. MOTHER'S MAIDEN NAME KRAEGER	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 5 71 9 1	
18. INFORMANT JAMES GOS		ADDRESS 623 S. BELMONT AVE	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cirrhosis of Liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) NO			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/5/70			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 8-8-70	24C. NAME OF CEMETERY or CREMATORY HOLY ROSARY CEMETERY	24D. LOCATION (City, town, or county) (State) DUNDALK MARYLAND
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR JOHN M. WEBER & SONS INC 4015 CHESTER ST.	

Know all men by these presents, that _____ of the County of _____ State of _____ do hereby certify that _____ of the County of _____ State of _____ was born on the _____ day of _____ 19____ at _____ Texas.

Witness my hand and seal of office this _____ day of _____ 19____.

County Clerk

Notary Public

Witness

Witness

Witness

Witness

Witness

Witness

Witness

1

70 7809

BALTIMORE CITY HEALTH DEPARTMENT

C-636

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7809

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Louise E. Carter		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 8 3 70 11:10 PM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 612 Gold St.		3. DATE PRONOUNCED DEAD Month Day Year 8 3 70 11:10 PM	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1501			
6. SEX female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.
9. DATE OF BIRTH 6/12/27		10. AGE (In years lost birthday) 42	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	E. STREET AND NUMBER 612 Gold St.
13. FATHER'S NAME Leonard Howard			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		14B. KIND OF BUSINESS OR INDUSTRY City	15. MOTHER'S MAIDEN NAME Violet
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 220-22-2508	18. INFORMANT ADDRESS Mrs Phyllis Stokes, 125 Cherry Lane

19. 371.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	CAUSE OF DEATH Fatty alteration of liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
	(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
	(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
	(C) _____			

20A. DATE OF OPERATION 2	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Deputy Chief Medical Examiner		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 8/4/70			

24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/8/70	24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery	24D. LOCATION (City, town, or county) (State) A A county M
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970	25B. NAME OF REGISTRAR Robert E. Fisher, MD	25C. FUNERAL DIRECTOR Adolphus Halstead	ADDRESS 1206 W North Av

1000

EXHIBIT - STATE OF TEXAS

INVESTIGATION

REPORT

C

ALFRED H. BOYD

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-1-83 BY SP-5 JMB

REASON FOR DECLASSIFICATION

EXEMPT FROM AUTOMATIC DECLASSIFICATION

DATE 10-1-83 BY SP-5 JMB

REASON FOR DECLASSIFICATION

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																	
70 7810 CERTIFICATE OF DEATH					70 7810 REG. NO.												
BIRTH NO. <i>K-422</i>					1. NAME OF DECEASED (Type or Print) <i>Kowalczyk, Catherine</i>					2. DATE AND HOUR OF DEATH <i>8/5/70 9:10 A.M.</i>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Balto., Md.</i> B. COUNTY <i>DRA 3202</i>					5. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>33 Johns Hopkins Hospital</i>					E. STREET AND NUMBER <i>323 S. Durham Street</i>					CATHERINE							
5. SEX <i>Female</i>		6. RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8/18/00</i>		9. AGE In years <i>69</i> (last birthday)		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>					11. BIRTHPLACE (State or foreign country) <i>Poland</i>							
12. CITIZEN OF WHAT COUNTRY? <i>Poland</i>					13. FATHER'S NAME <i>Martin Hulak</i>					14. MOTHER'S MAIDEN NAME <i>Catherine</i>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>					16. SOCIAL SECURITY NO. <i>218-01-9726</i>					17. INFORMANT ADDRESS <i>Joseph A. Kowalczyk 323 S. Durham Street</i>							
18. <i>402X1</i> CAUSE OF DEATH										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>C.V.A.</i>										<i>Six days</i>							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Arterial Hypertension + Pyelonephritis</i>																	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).																	
19A. DATE OF OPERATION <i>—</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>			20A. AUTOPSY? (Yes or No) <i>No</i>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <i>7/31/70</i> 19 <i>70</i> to <i>8/5/70</i> 19 <i>70</i> that (I) (we) lost saw the deceased alive on <i>8/5/70</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										23A. SIGNATURE <i>William Feder</i>				23B. DATE SIGNED <i>8/5/70</i>			
23C. PHYSICIAN'S NAME (Type) <i>William Feder, M.D.</i>					23D. ADDRESS <i>601 N. Broadway Balto., Md. 21205</i>												
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>8/8/70</i>			24C. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>								
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 6 1970</i>					25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			25C. FUNERAL DIRECTOR ADDRESS <i>George A. Weber 705 South Ann Street</i>									

1907-1908

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1908

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
1-625 70 7811 (3) CERTIFICATE OF DEATH										REG. NO. 70 7811	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>(Largent) Hersey Sands</i>				2. DATE AND HOUR OF DEATH <i>8/4/70</i> <i>4:00 A.M.</i>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Univ. of Maryland Hosp.</i>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>BALTO.</i> C. CITY OR TOWN <i>Balt.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>637 ORPINGTON</i>					
5. SEX <i>Male</i>	6. RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/4/09</i>	9. AGE (In years last birthday) <i>60</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanics</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>EASTERN PRODUCTS Co.</i>		11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>MILLARD J. LARGENT</i>				14. MOTHER'S MAIDEN NAME <i>BERTHA K. WISNER</i>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>236-03-8137</i>		17. INFORMANT <i>Chart 3512 Fred. ADDRESS App. G. TRUMAN Schaab</i>					
18. <i>450X1</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>massive pulmonary embolism and cardio pulmonary failure</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Renal failure</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
19A. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Specify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>7/15</i> 19 <i>70</i> to <i>8/4</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>8/4</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>E. Shapiro</i>						23B. DATE SIGNED <i>8/4/70</i>					
23C. PHYSICIAN'S NAME (Type) <i>Robert E. Taylor, M.D.</i>						23D. ADDRESS <i>22 S. Greenest. Balt. Md. 21229</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>Aug 7, 1970</i>		24C. NAME of CEMETERY or CREMATORY <i>Good Shepherd Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Howard Co. Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 6 1970</i>				25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>BALTO. MD. ADDRESS 21229 G. TRUMAN Schaab 3512 Frederick Ave.</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 7812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 70 7812

BIRTH NO.		1. NAME OF DECEASED (Type or Print) STELLA CAPCINSKI (A/K as Stefania Capcinski)		2. DATE AND HOUR OF DEATH 8-4-70 11:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL 35			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1838 GOUGH ST. 202		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/22/1917	9. AGE (in years last birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY Lining Maker Clothing Mfg.		11. BIRTHPLACE (State or foreign country) POLAND	
13. FATHER'S NAME Ludwik Wlodkowski WL ODKOWSKI			14. MOTHER'S MAIDEN NAME Veronica Tijewska		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 212-03-3716A		17. INFORMANT ADDRESS Mr. Walter Capcinski, 1838 Gough St	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) diabetes mellitus with gangrene of foot				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years 2 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ERROR when					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). septicemia generalized atherosclerosis					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/12 19 70 to 8/4 19 70 and that (I) (we) lost saw the deceased alive on 8/4 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W.B. Maniago, M.D.			23B. DATE SIGNED 8/4/70		
23C. PHYSICIAN'S NAME (Type) WILMA B. MANIAGO, M.D.			23D. ADDRESS CHURCH HOME & HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/70		24C. NAME OF CEMETERY OR CREMATORY Holy Rosary	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE.			



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C-516

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7813

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

7813

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BIRTH NO.		1. NAME OF DECEASED (Type or Print) CARRIE CHAMBERS		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour		M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD August 4, 1970		Month Day Year Hour		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2002		5:05 P.M.	
6. SEX Female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH March 3, 1901		10. AGE (in years last birthday) 69		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Unknown	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Daisy Brooks		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 213-07-88170	
18. INFORMANT James Williams		ADDRESS 2233 Penrose Ave.		19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/5/70			
24A. BURIAL CREMATION, REMOVAL—(Specify) Burial		24B. DATE 8/8/1970		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 3921 Lombard St.			

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10

WILLIAM H. WATSON, JR.

WILLIAM H. WATSON, JR.

WILLIAM H. WATSON, JR.

WILLIAM H. WATSON, JR.

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WILLIAM H. WATSON, JR.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7814	
W-630 BIRTH NO. 70 7814		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WARD Lillian			2. DATE AND HOUR OF DEATH 8/13/70 1:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1502		
FULL NAME OF HOSPITAL OR INSTITUTION Key Circle Hospice			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female			6. RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
16. FATHER'S NAME John Johnson			14. MOTHER'S MAIDEN NAME Maggie ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 213-20-3986		17. INFORMANT Katherine Little
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Circulatory failure 2 Hrs (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD - atrial flutter 3 yrs (C) DUE TO, OR AS A CONSEQUENCE OF: COA - pt hemiparesis 1 yr		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4:30 19 70 to 8-3 19 70 that (I) (we) last saw the deceased alive on 8-2 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard D. Digler			Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-3-70
23C. PHYSICIAN'S NAME (Type) RICHARD D. DIGLER			23D. ADDRESS 1. W. OVERLEA AVE Balto 21206		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/16/1970		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Charles S. Powell			



FUNERAL DIRECTOR: IMPORTANT

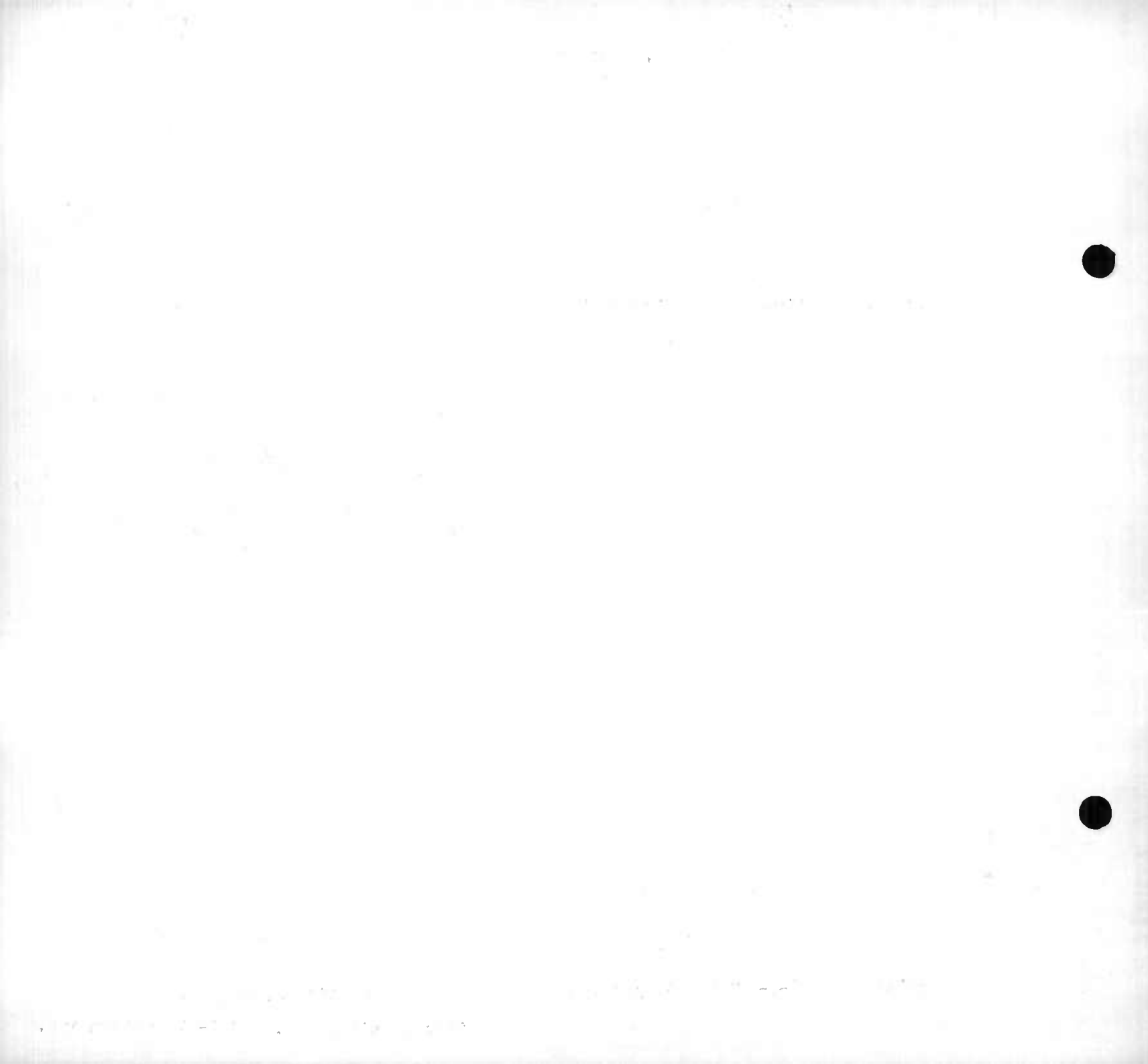
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 7815	
S-524 70 7815				REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Joseph Singletary		July 31, 1970 106:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
University of Maryland			Maryland		
38			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			2871 W. Lonsdale St.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2-18-12	58	Laborer
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			South Carolina		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Nathan Singletary			Ella ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
No			215-10-0899		Mary Bailey 2871 W. Lonsdale St
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Metastatic Adenocarcinoma		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Adenocarcinoma of Rectum		
			(C)		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
7-17-70		Small bowel obstruction		Yes No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 12 1970 to July 31 1970 that (I) (we) last saw the deceased alive on July 31 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
H. E. Bondy M.D.				July 31, 1970	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
H. E. Bondy M.D.				Dept. of Surgery	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		8/6/70		Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
Baltimore Md.		John E. ...		Williams Funeral Home	
25A. DATE EC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 6 1970		John E. ...		Williams Funeral Home	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

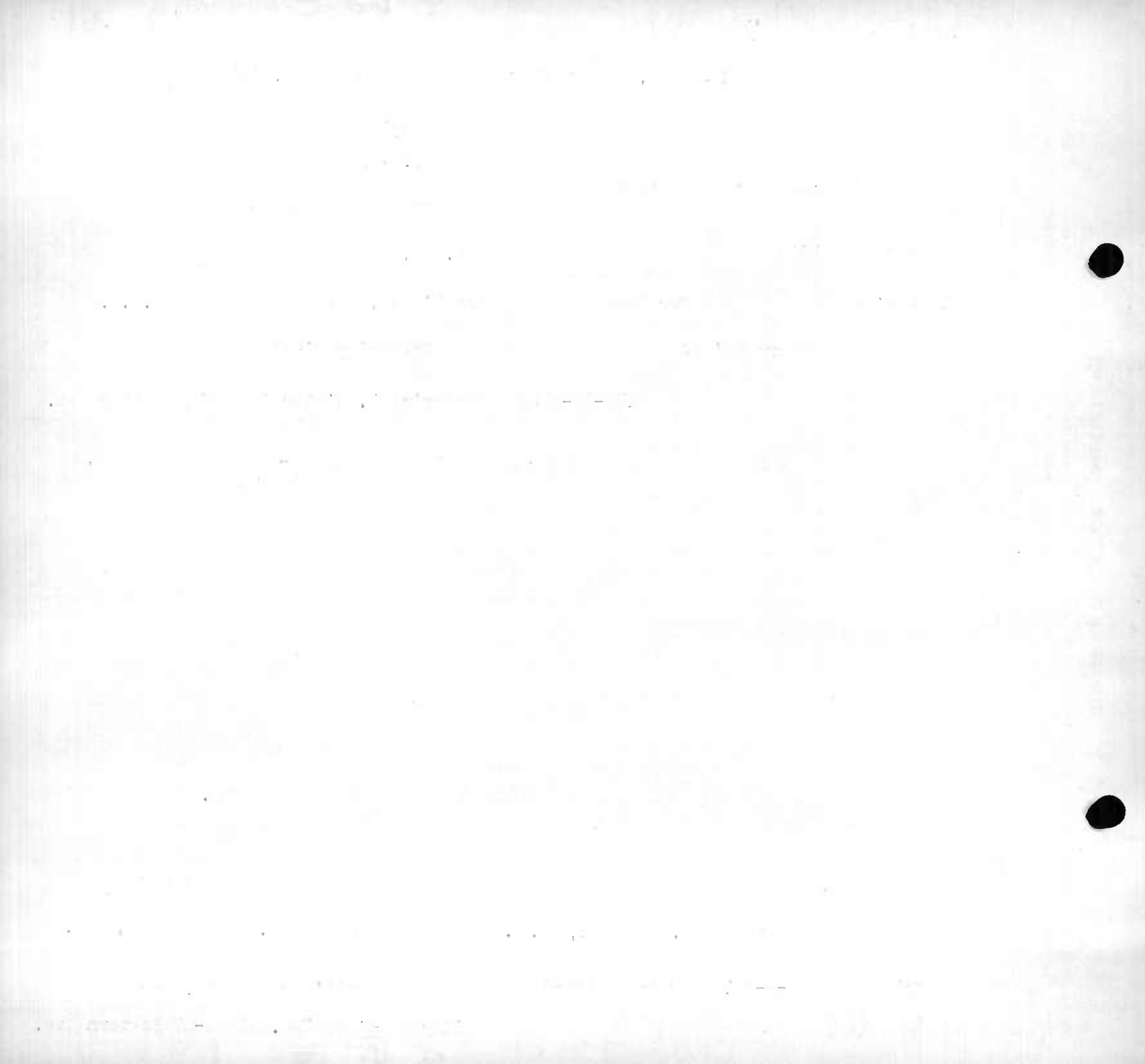
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7816	
L-550 70 7816 CERTIFICATE OF DEATH					
BIRTH NO. L-550		NAME OF DECEASED JOHN J. LANAHAN		2. DATE AND HOUR OF DEATH 8.4.70 6:25 P.M.	
1. NAME OF DECEASED (Type or Print) John J. LANAHAN		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hospital Baltimore MD. 21231		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY city		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M 6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5.5.00 9. AGE (In years last birthday) 70 yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Retired		10B. KIND OF BUSINESS OR INDUSTRY Baltimore City		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 218-07-2175		17. INFORMANT John Lawrence Lanahan ADDRESS 4702 Shawrock Ave.	
18. 410.7 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial infarction		- 2 days	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: leading to cardiogenic shock			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) A.C.H.D.		heart block yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 8.3.1970 to 8.4.1970 that (H) (we) last saw the deceased alive on 8.4.1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Adam Samad MD		23B. DATE SIGNED 8.4.1970		23C. PHYSICIAN'S NAME (Type) TBDUS SAMAD MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-7-1970		24C. NAME of CEMETERY or CREMATORY Holy Redeemer	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. ADDRESS 1901-07 Eastern Ave.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		24E. LOCATION (City, town, or county) (State) Baltimore, Maryland			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

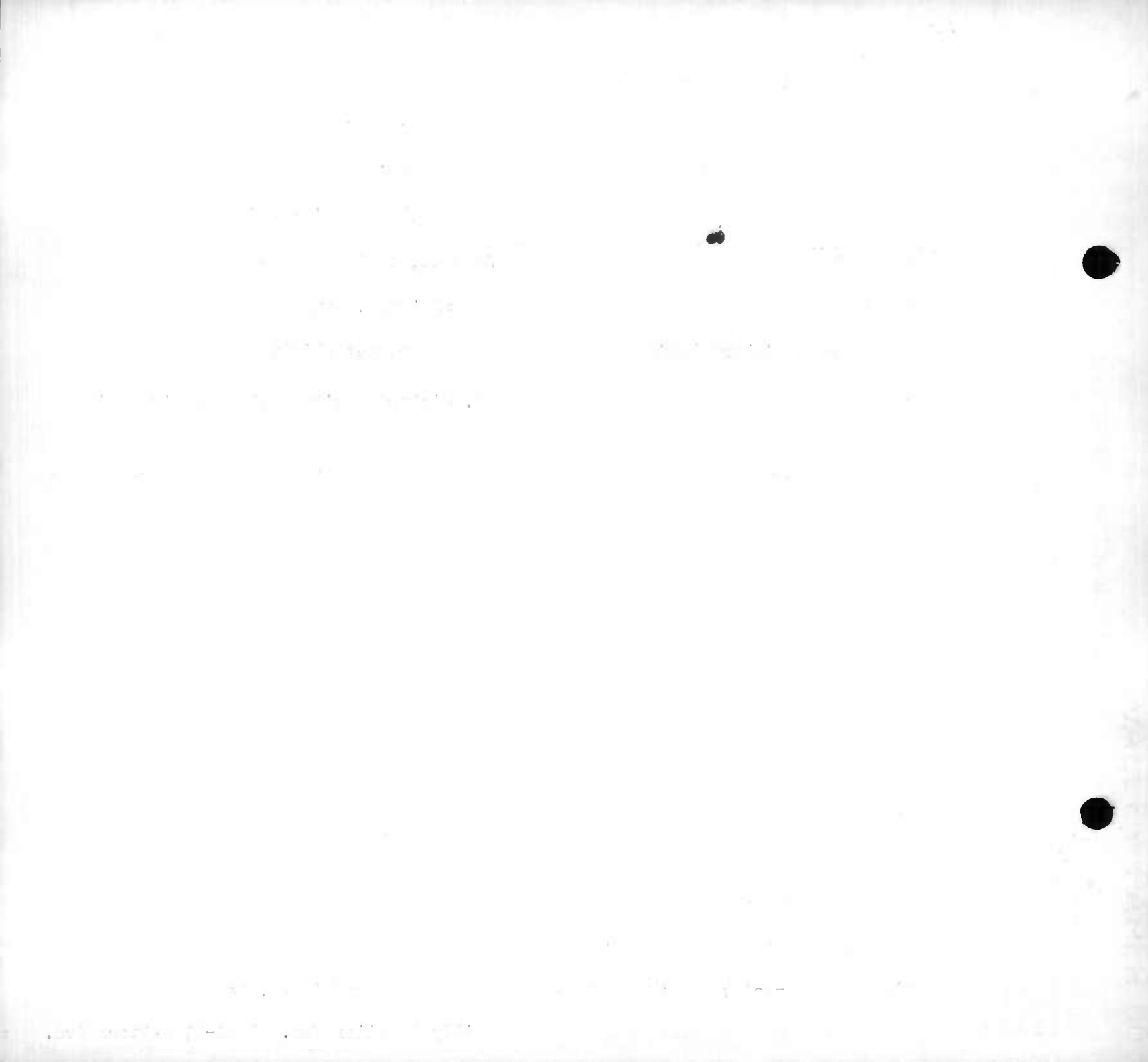
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	70 7817
W-536 BIRTH NO.		70 7817 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
CAROLINE M. WINTERLING			August 4, 1970		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital			A. STATE Maryland		
			B. COUNTY 2609		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3724 Foster Avenue		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1897	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Harry Haines			14. MOTHER'S MAIDEN NAME Catherine Eisel		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-2445	17. INFORMANT Frederick G. Winterling		
			ADDRESS 3724 Foster Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio-vascular Disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.		
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 30, 1970 to Aug. 4, 1970, that (I) was lost saw the deceased alive on July 30, 1970 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was did (did not) view the body after death.					
23A. SIGNATURE Clarence W. LeDoux, M.D.				23B. DATE SIGNED 8/5/70	
23C. PHYSICIAN'S NAME (Type) Clarence W. LeDoux, M.D.				23D. ADDRESS 3023 Eastern Ave. Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-8-1970		24C. NAME OF CEMETERY or CREMATORY Sacred Heart	
				24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970		25B. NAME OF REGISTRAR Robert E. Gabor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

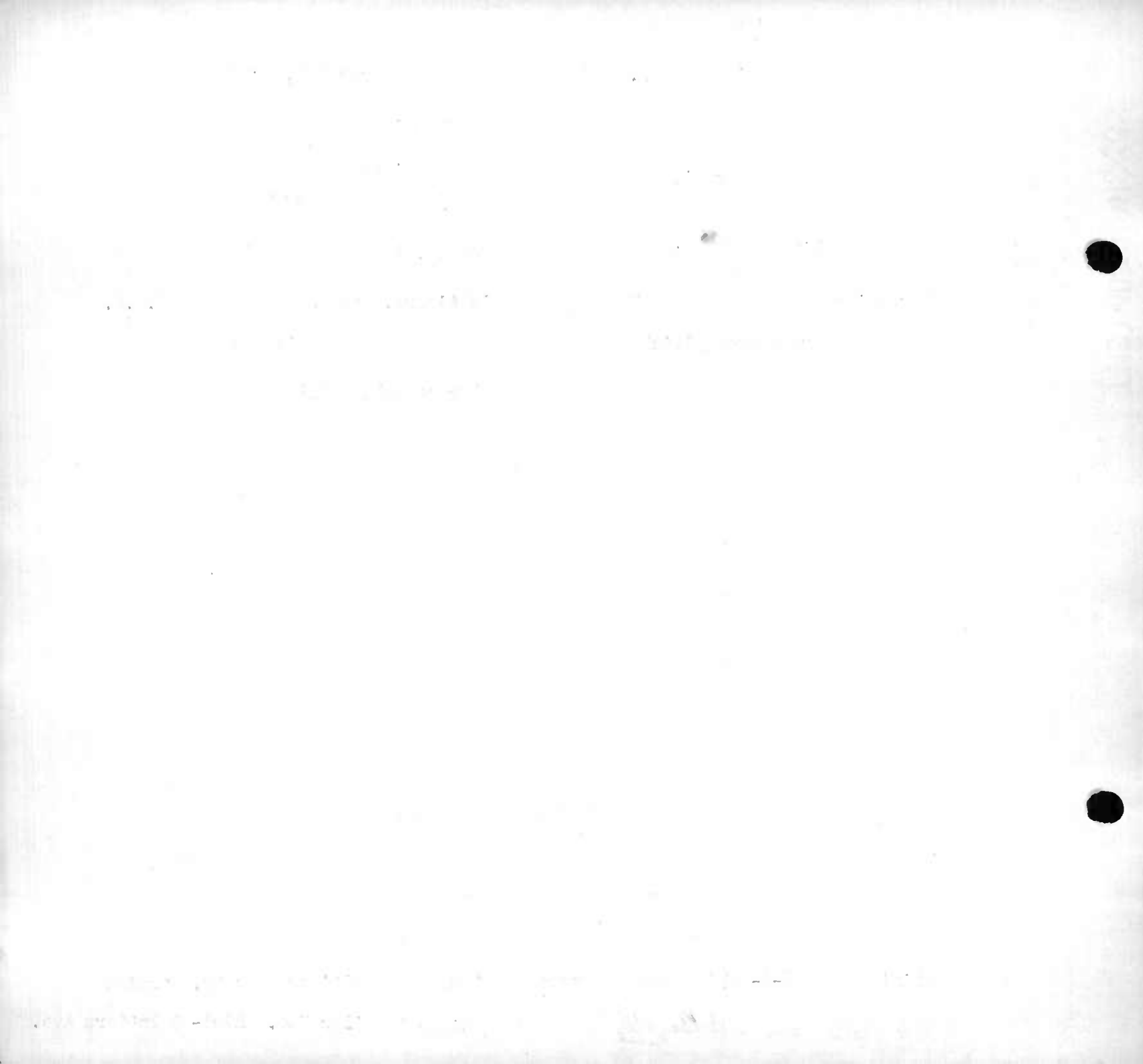
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7818
<div style="display: flex; justify-content: space-between;"> L-200 67-12066 70 7818 </div>				<div style="font-size: 1.5em;">45</div> <div style="font-size: 1.5em;">P.M.</div>
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 67-12066 70 7818 </div> <div> CERTIFICATE OF DEATH </div> </div>				
1. NAME OF DECEASED (Type or Print) ERIC M. LEWIS		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> 8-2-70 6 P.M. </div>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION 37 </div> <div> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mercy </div> </div>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) <div style="display: flex; justify-content: space-between;"> <div> A. STATE Maryland </div> <div> B. COUNTY 2642 </div> </div>		
		C. CITY OR TOWN Baltimore	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4218 Parkside Drive		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1967	
		9. AGE (In years last birthday) 3	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME John Richard Lewis		14. MOTHER'S MAIDEN NAME Margaret Plichta		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT J. Richard Lewis	
		ADDRESS 4218 Parkside Drive		
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div> (A) IMMEDIATE CAUSE ACUTE LEUKEMIA DUE TO, OR AS A CONSEQUENCE OF: </div> <div> (B) DUE TO, OR AS A CONSEQUENCE OF: </div> <div> (C) </div> </div>				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION D	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (1) (this hospital) attended the deceased from 7/27 19 70 to 8/2 19 70 that (1) (we) lost saw the deceased alive on 8/2 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <div style="display: flex; justify-content: space-between;"> <div> J. Eufemio </div> <div> M.D. </div> </div>			23B. DATE SIGNED 8/2/70	
23C. PHYSICIAN'S NAME (Type) JOHNNY EUFEMIO M.D.			23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-5-1970	24C. NAME of CEMETERY or CREMATORY Holy Redeemer	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.	ADDRESS 1901-07 Eastern Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

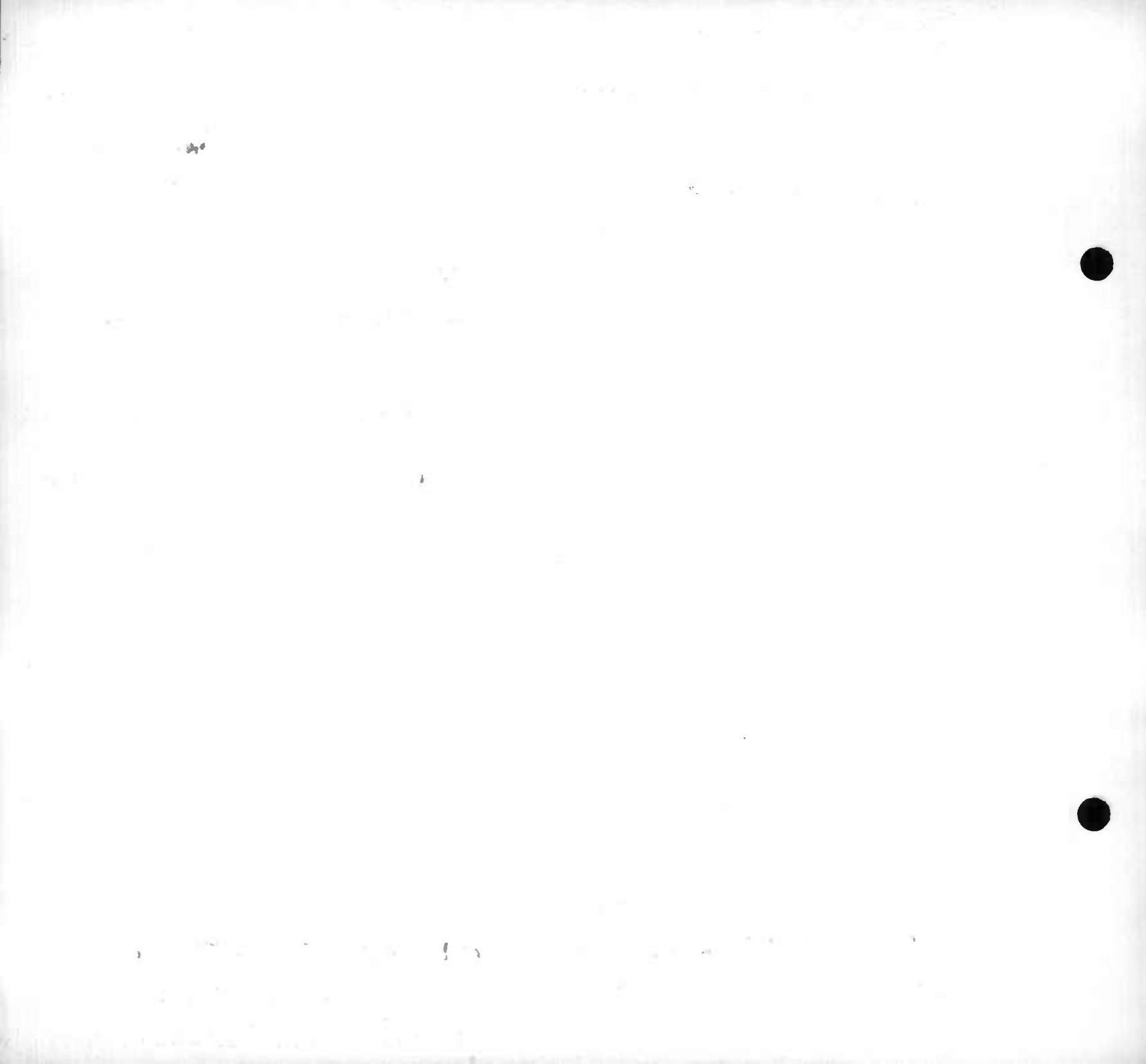
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	70 7819
BIRTH NO. K-500		70 7819		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARGARET G. KUHN		August 3, 1970	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Edgewood Nursing Home		A. STATE Maryland			
		B. COUNTY 2611			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		3219 Fleet Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days Hours Min.
Female	White	Widow	May 20, 1889	81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Own Home		Baltimore, Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Bartholomew Gleich			Fiedler		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Charles Kuhn 3219 Fleet Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
431.91		(A) CEREBRAL HEMORRHAGE DUE TO		10 DAYS	
ANTECEDENT CAUSES		(B) ARTERIO SCLEROSIS DUE TO		10 YRS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7/25 19 70 to 8/3 19 70 that (I) (we) last saw the deceased alive on 8/3 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Leonard P. Berger M.D.				8/3/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
LEONARD P. BERGER M.D.		8100 HARKFORD RD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8-6-1970		Sacred Heart Cemetery	
				Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 6 1970		Robert E. Taylor, M.D.		Lilly & Zeiler Inc. 1901-07 Eastern Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 7820		REG. NO. 70 7820	
BIRTH NO. <u>5-530</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Genesta Smith</u>				2. DATE AND HOUR OF DEATH <u>7-23-70</u> <u>2:38 a.m.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>2222 Elsinor Ave</u>				A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>Female</u>				6. RACE <u>Colored</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>5/1/1890</u>			
9. AGE (In years last birthday) <u>80</u>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>			
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Novada Outlaw</u>				ADDRESS <u>1121 Harker Ave</u>			
18. <u>412.4 I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardio-vascular disease</u>				<u>8 years</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Epilepsy</u>				<u>?</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>None</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) <u>no</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>July 16</u> 19 <u>65</u> to <u>July 23</u> 19 <u>70</u> that (I) (<u>we</u>) last saw the deceased alive on <u>July 16</u> 19 <u>70</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>John E. T. Camper, M.D.</u>				23B. DATE SIGNED <u>7-29-70</u>			
23C. PHYSICIAN'S NAME (Type) <u>JOHN E. T. CAMPER M.D.</u>				23D. ADDRESS <u>699 N. CAREY ST. BALTO. MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>7/29/70</u>			
24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>				24D. LOCATION (City, town, or county) (State) <u>A.A.C.U. Md.</u>			
25A. DATE RECD. BY HEALTH DEPT. <u>AUG 6 1970</u>				25B. NAME OF REGISTRAR <u>Joseph E. Taylor, R.D.</u>			
25C. FUNERAL DIRECTOR <u>Joseph L. Russ</u>				ADDRESS <u>2222 N. North Ave</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

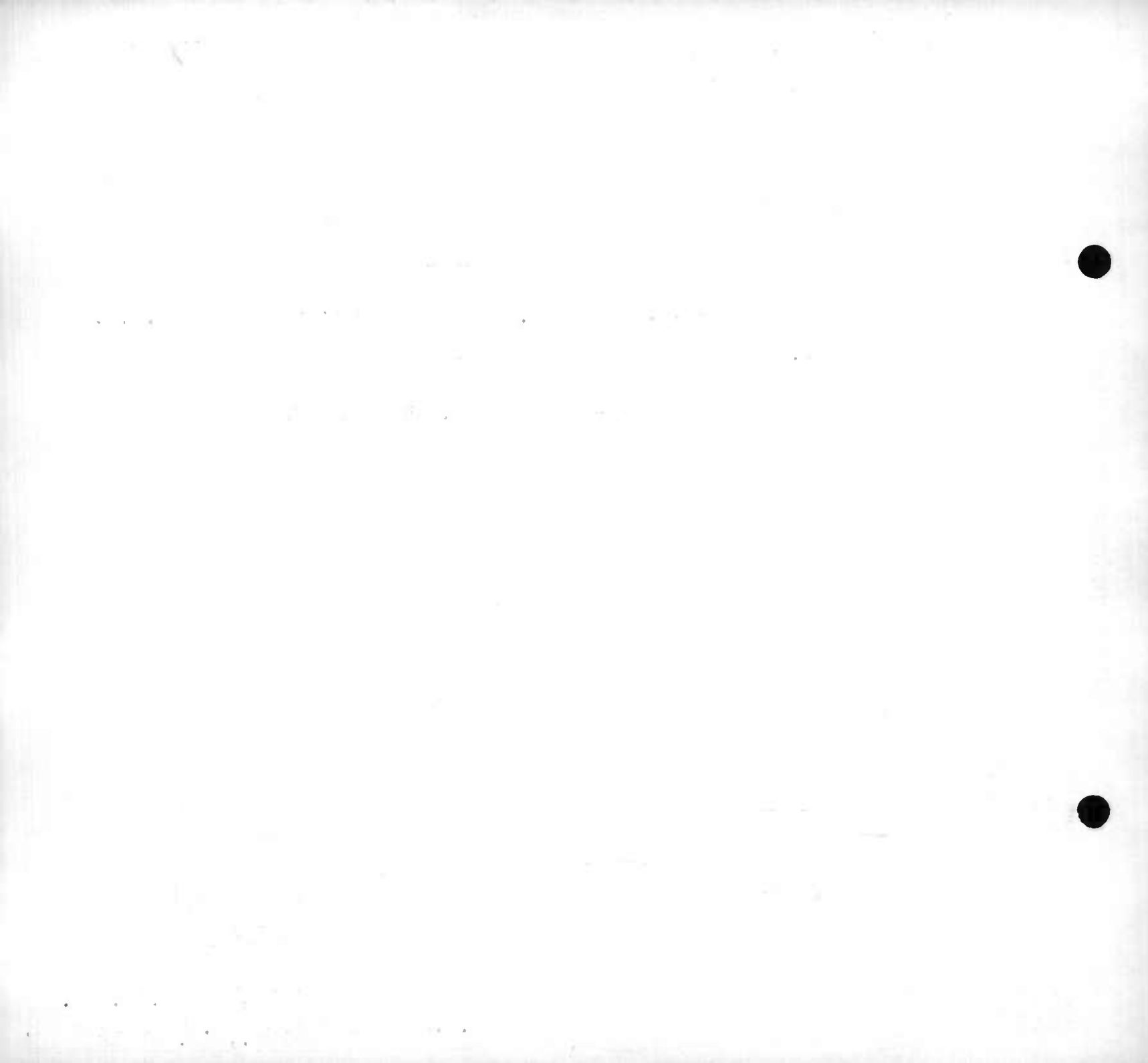
M-600 70 7821				BALTIMORE CITY HEALTH DEPARTMENT		X	
BIRTH NO.				CERTIFICATE OF DEATH		REG. NO. 70 7821	
1. NAME OF DECEASED (Type or Print) <u>MOORE, BESSE J.</u>				2. DATE AND HOUR OF DEATH <u>Aug. 6, 1970</u> <u>4:40</u> a. m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Keswick</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Keswick</u> B. COUNTY <u>Allen</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Keswick</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>700 W. 40th St.</u>							
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-11-1871</u>	9. AGE (In years last birthday) <u>99</u>	10. Under 1 Yr. Months	11. Under 24 Hrs. Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>H. S. Glaze</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Jewell</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>V. M. Crouch</u>	
18. <u>440.91</u> CAUSE OF DEATH				ADDRESS <u>Keswick</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerosis</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		<u>6 yrs</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Osteoarthritis</u>				(B) DUE TO, OR AS A CONSEQUENCE OF:		<u>9 yrs</u>	
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>2 Jan</u> 19 <u>62</u> to <u>6 Aug</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>6 Aug</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Aubrey D. Richardson</u>				23B. DATE SIGNED <u>6 Aug 1970</u>			
23C. PHYSICIAN'S NAME (Type) <u>Aubrey D. Richardson, MD</u>				23D. ADDRESS <u>700 West 40th Street, Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>8-6-67</u>		24C. NAME of CEMETERY or CREMATORY <u>Greenmount</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 6 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fabe, M.D.</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co., Balto., Md.</u>		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

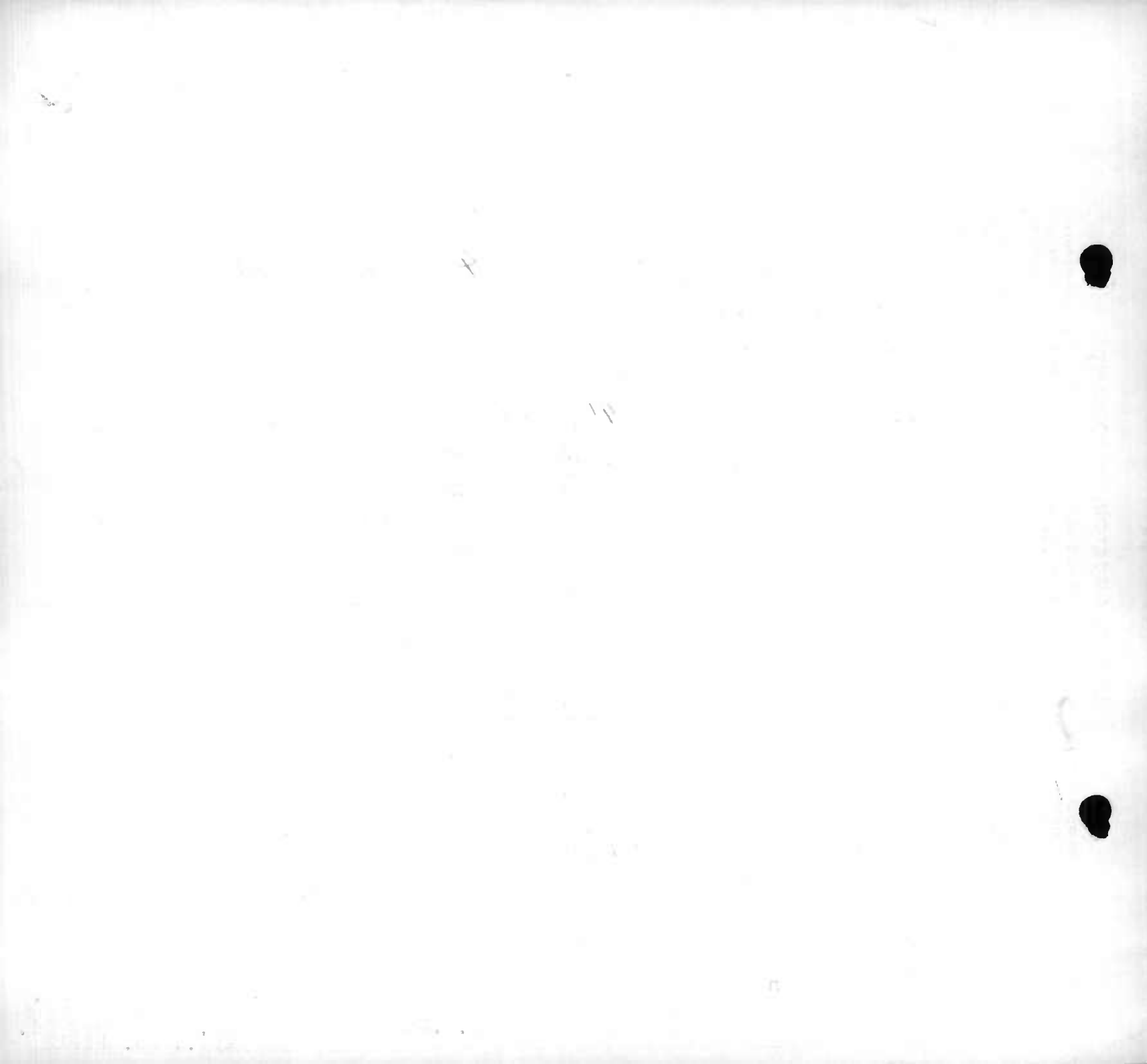
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7822</u>	
8-540 70 7822				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Kenneth John Rummel</u>			2. DATE AND HOUR OF DEATH <u>August 5, 1970</u> <u>1:15 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>1201</u>		
			C. CITY OR TOWN <u>Baltimore,</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>311 Suffolk Rd</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-23-93</u>	9. AGE (in years last birthday) <u>77</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Consulting Engineer-S.T. Powell Co.</u>			11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William D. Rummel</u>			14. MOTHER'S MAIDEN NAME <u>Effie Mae Bassett</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>113-20-9922</u>		17. INFORMANT <u>Mrs. Helen Rummel</u> ADDRESS <u>(Same)</u>
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>(A) IMMEDIATE CAUSE ① Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: <u>(B) ② Anterior Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF: <u>(C) ③ Bilateral acute suppurative pyelonephritis with papillitis</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/1/1970</u> to <u>8/5/1970</u> that (I) (we) last saw the deceased alive on <u>8/5/1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>K Lwin</u>			23B. DATE SIGNED <u>8/6/70</u>		23C. PHYSICIAN'S NAME (Type) <u>KYI K LWIN</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>8/8/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 6 1970</u>			25B. NAME OF REGISTRAR <u>Robert E. Fisher, Jr.</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Rd. Balto., Md. 21212</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 7823	
CERTIFICATE OF DEATH				REG. NO. 70 7823	
1. NAME OF DECEASED (Type or Print) <i>Harry - KRATZ</i>		2. DATE AND HOUR OF DEATH <i>August 5 1970 9 05 AM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>North Charles Gen. Hosp</i>		A. STATE <i>Md.</i>		B. COUNTY <i>Baltimore</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>4-19-97</i>		9. AGE (in years last birthday) <i>73</i>		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Commercial Credit</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Frederick Kratz</i>			
14. MOTHER'S MAIDEN NAME <i>Emma Louise Schinger</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>341-038611</i>		17. INFORMANT <i>Wilbur Kratz (Same)</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenie, etc. It means the disease, injury or complication which caused death.) <i>Arteriosclerotic cardiovascular disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>C.V.A. & Rt. hemiparesis.</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>8/5/70</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8/5/70 120</i> 19 <i>70</i> to <i>8/5</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>8/5/70</i> 19 <i>70</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>V. Chitraplee</i>		23B. DATE SIGNED <i>Aug. 5, 1970</i>		23C. PHYSICIAN'S NAME (Type) <i>Vadhana Chitraplee</i>	
23D. ADDRESS <i>North Charles General Hosp</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			
24B. DATE <i>8/8/1970</i>		24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 6 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>		25C. FUNERAL DIRECTOR <i>H.W. Jenkins & Sons Co.</i>	
25D. ADDRESS <i>4905 York Rd. Balto., Md. 21212</i>					



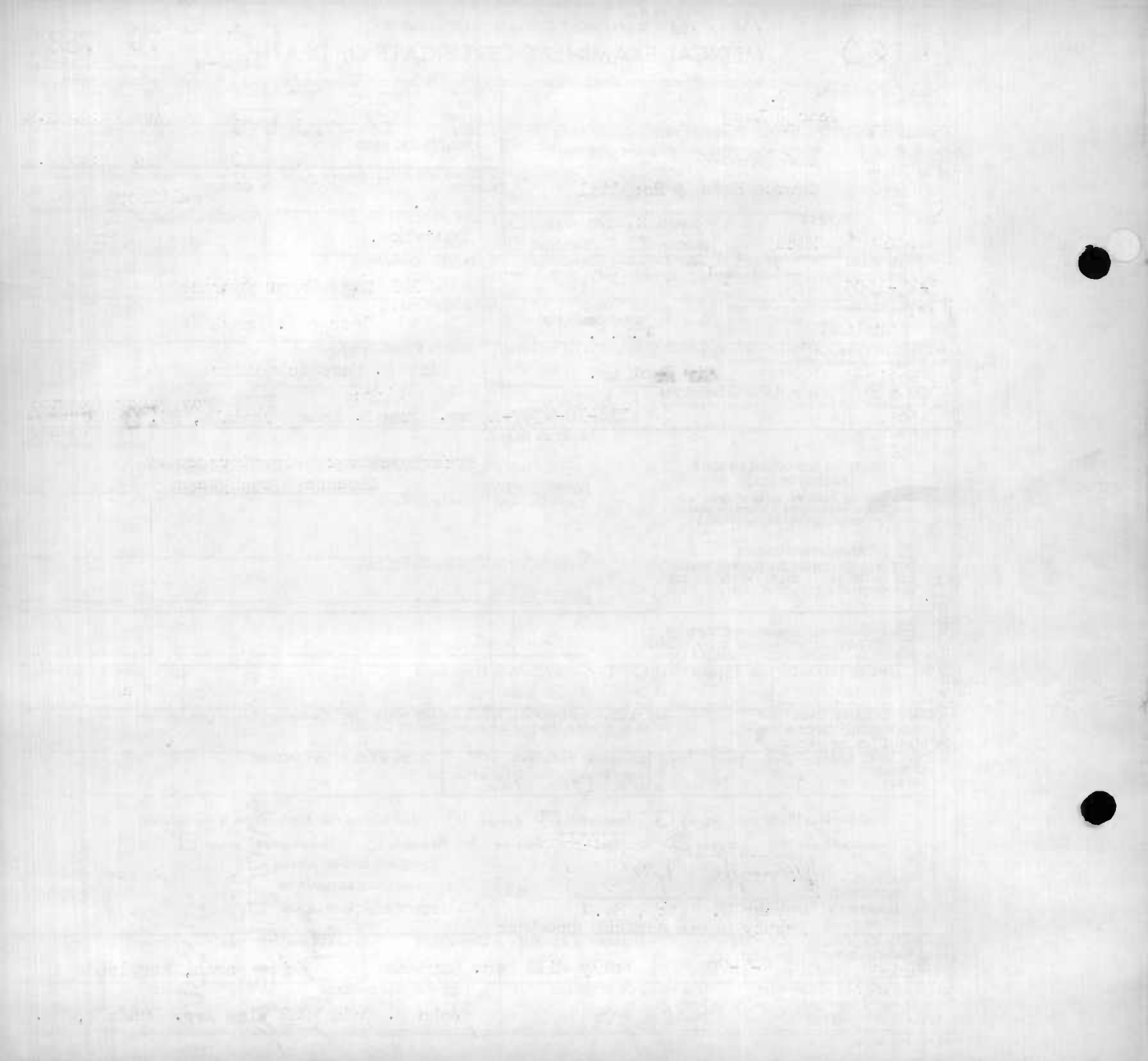
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 7824

BIRTH NO.

1. NAME OF DECEASED (Type or Print) T. George Lang		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 8 3 70 1:45 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home & Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 3 70 1:45 p.m.	
6. SEX male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore	
9. DATE OF BIRTH 3-23-1905		10. AGE (In years lost birthday) 65	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		14B. KIND OF BUSINESS OR INDUSTRY Air Duct Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 216-10-4347	
18. INFORMANT: wife: Mrs. Mary L. Lang		ADDRESS 2703 Gray Manor Terrace Dundalk, Md. 21222	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease & emphysema (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) no	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/4/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-7-70	
24C. NAME OF CEMETERY or CREMATORY Holly Hill Mem. Gardens		24D. LOCATION (City, town, or county) (State) White Marsh, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md.	



70

7825

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7825

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CALVERT W. PRITCHARD

2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)3. DATE PRONOUNCED DEAD Month Day Year Hour
8 1 1970 7:55 A.M.5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)
A. STATE Md. B. COUNTY 1401

1100 Linden Ave.

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

Dec. 28, 1903

10. AGE (In years last birthday)

66

11. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

301 Mc Mechen St. # 21217.

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Calvert Pritchard

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

Beth. Steel Co.

15. MOTHER'S MAIDEN NAME

Elizabeth Heckman

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

215-09-6073

18. INFORMANT

Elizabeth M. Pritchard:

ADDRESS

Same.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Cranio-cerebral injuries
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1100 blk. Linden Ave. 1401

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 8-1-70 A.m.

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Unk.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-1-70

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-5-70.

24C. NAME of CEMETERY or CREMATORY

Meadowridge Memorial Cem.

24D. LOCATION (City, town, or county) (State)

Elkridge, Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 6 1970

25B. NAME OF REGISTRAR

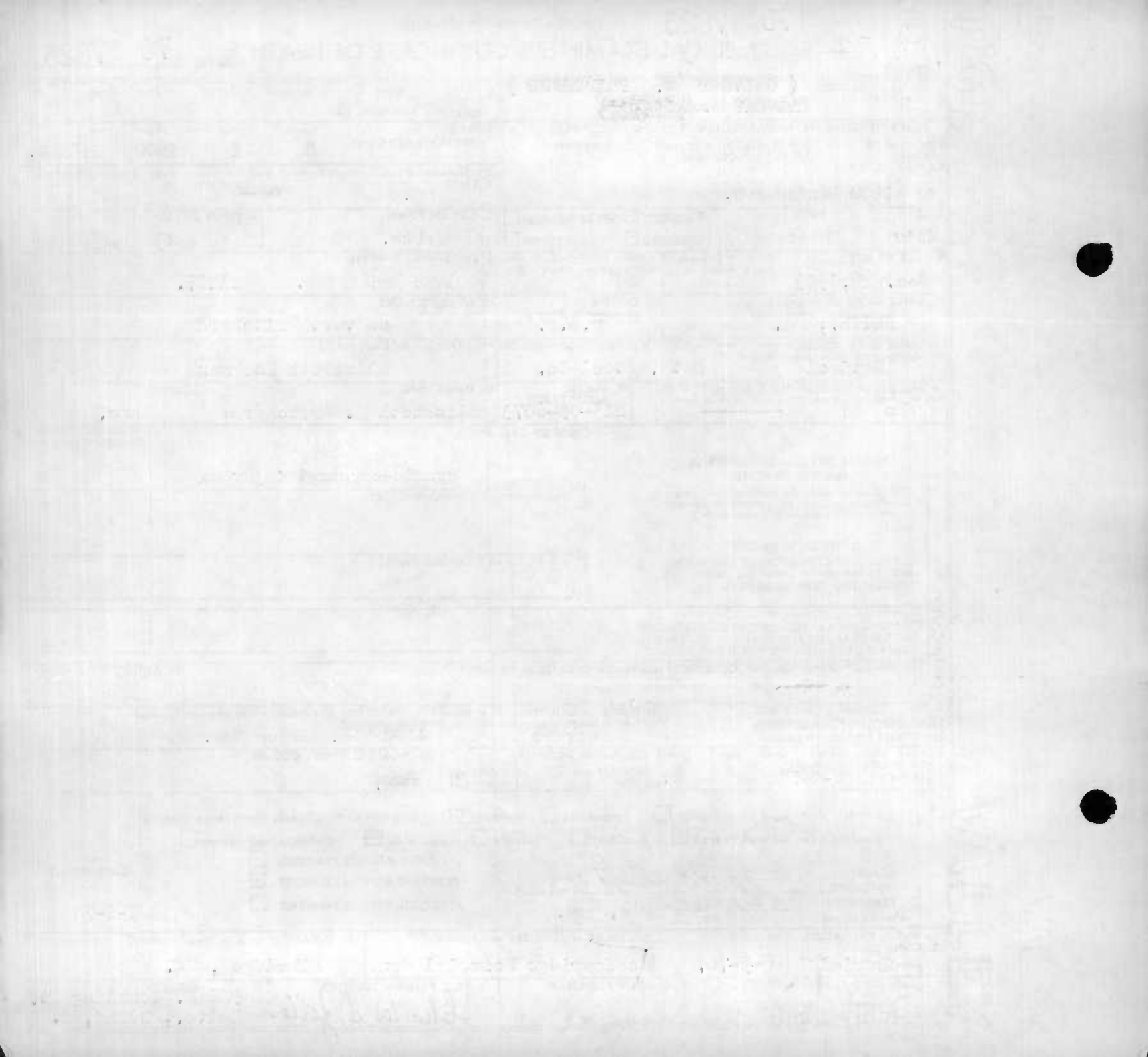
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Charles A. Gaylor

ADDRESS

901 S. Conkling St. Balto., 21224, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 7826	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. <u>20-13699</u>		1. NAME OF DECEASED (Type or Print) <u>LYLES, BABY Boy</u>		2. DATE AND HOUR OF DEATH <u>7-24-70 1:55 P</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>U.S. Md. Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Baltimore</u> B. COUNTY <u>1501</u>	
5. SEX <u>Male</u>		6. RACE <u>Negro</u>		C. CITY OR TOWN <u>md</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/23</u>		9. AGE (In years last birthday) <u>1</u> If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	
13. FATHER'S NAME <u>Stanley Harper</u>		14. MOTHER'S MAIDEN NAME <u>Irene Lyles</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>mother</u> ADDRESS <u>3806 Fairview Ave</u>	
18. <u>486X I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u>	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(B) <u>prematurity</u> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				(C) _____	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				_____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u>				_____	
19A. DATE OF OPERATION <u>7/24</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>NA</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>7/23</u> 19 <u>70</u> to <u>7/24</u> 19 <u>70</u> that (2) (we) last saw the deceased alive on <u>7/24</u> 19 <u>70</u> and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John Payne</u>				23B. DATE SIGNED <u>7/29/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ch. Dis</u>				23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL</u>	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <u>8-4-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>UNIVERSITY MEDICAL SCHOOL</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 6 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u> ADDRESS	

1522 N. Strickland pt

called hospital 9/24/70

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 70 7827	
S-610 70 7827		BIRTH NO. 70-12132			
1. NAME OF DECEASED (Type or Print) BABY SHARPE (girl)		2. DATE AND HOUR OF DEATH 7/13/70 10:50 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 38 U. MD Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution's residence before admission) A. STATE MD 21234 B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/13/70 9. AGE (In years last birthday) 5 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
11. BIRTH PLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME Norman Sharpe		14. MOTHER'S MAIDEN NAME Lynne Foley			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT chari ADDRESS	
18. 740X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) anencephalic		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/13 7/13 19 70 to 7/13 19 70 that we last saw the deceased alive on 7/13 19 70 and that we (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.					
23A. SIGNATURE John Payne MD		23B. DATE SIGNED 7/13/70		23C. PHYSICIAN'S NAME (Type) JOHN PAYNE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8-4-70		24C. NAME of CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 7828	
CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Baby Girl Wilson		27/7/70 6:40 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
380 U. of Md. Hospital			MARYLAND, BALTIMORE		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			2418 Seabury Rd. Baltimore Md		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. Under 1 Yr. Months Days
F	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	17 July 70	8	0 10 - -
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
infant				Baltimore Md	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Robert E. Wilson			Gloria A. Brown		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
no					Mother (as above)
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
444.2			cardiac arrest		
[This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]			(A) IMMEDIATE CAUSE		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			pneumonia + infarcted Bowel		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			probable roborus		
			(C) Prematurity		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			10 min		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
27/10/70		infarcted Bowel		0	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
no					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from 17 July 1970 to 27 July 1970 that (we) lost saw the deceased alive on 27 July 1970 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John V. Payne M.D.				27 July 70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JOHN V. PAYNE M.D.				U. of Maryland Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATOR (City, town, or county) (State)	
		8-4-70		ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 6 1970		Robert E. Taylor, M.D.		UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

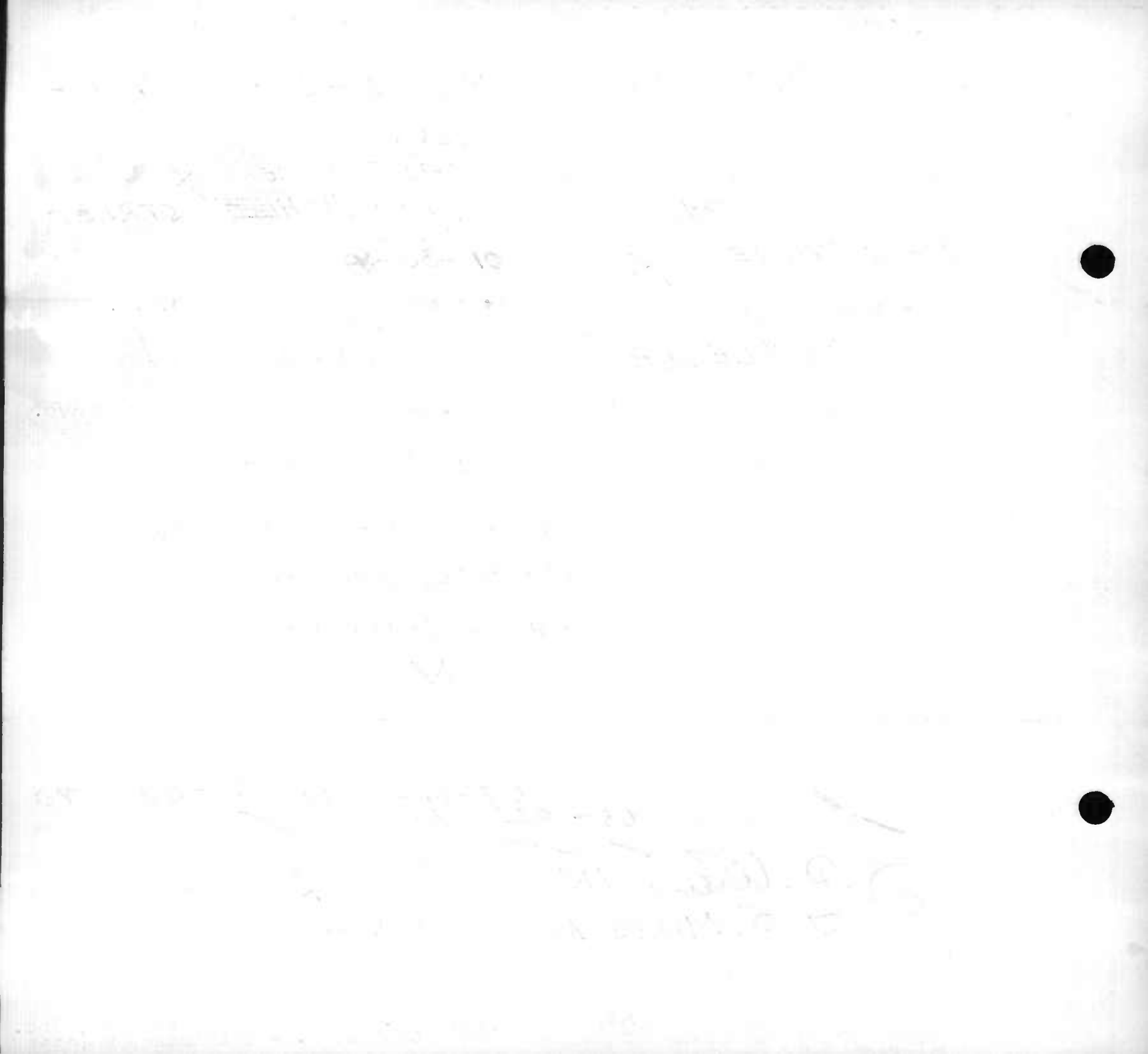
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7829	
CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Lynn, Bobby Gil		2. DATE AND HOUR OF DEATH 7-25-70 6:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 CMW. Hosp. of Md.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 2822 Borkent Dr. Balt., Md. 21225 B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2822 Borkent Dr. Balt., Md. 21225	
5. SEX Female	6. RACE American	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-23-70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 48 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) University of Maryland Hospital		12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME Lynn		14. MOTHER'S MAIDEN NAME Stella Lynn	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
18. 74691 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Heart failure (B) DUE TO, OR AS A CONSEQUENCE OF: Long. Heart Disease P.B. (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours 48 hours	
19A. DATE OF OPERATION 7-24-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED poor	
20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-23-70 to 7-25-70 and that (I) (we) last saw the deceased alive on 7-25-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Yupadre Vorasuben		23B. DATE SIGNED 7-25-70	
23C. PHYSICIAN'S NAME (Type) YUPADRE VORASUBEN		23D. ADDRESS University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8-4-70	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 6 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	
MORTUARY SERVICE - BCD			

6 Race Negro

FUNERAL DIRECTOR: IMPORTANT

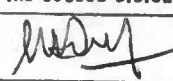
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> S-530 70 7830 BALTIMORE CITY HEALTH DEPARTMENT 70 7830 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. _____	
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) SMITH HOWARD M.	
2. DATE AND HOUR OF DEATH 8-3-70 4:30 A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1348		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3455 ASHLEY STREET		5. SEX MALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 01-30-99 9. AGE (in years last birthday) 71		If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME McCLELLAN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-5012	
17. INFORMANT Mrs. Margaret Blunt-4605 Asbury Ave.		ADDRESS _____	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SEPTICEMIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. URINARY TRACT INFECTION DIABETES MELLITUS II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). DIABETIC GANGRENE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
19A. DATE OF OPERATION _____		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
20A. AUTOPSY (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21E. INJURY OCCURRED _____		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (1) (this hospital) attended the deceased from 07-14-1970 to 08-03-1970 that (1) (we) last saw the deceased alive on 08-02-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		23A. SIGNATURE S. D. Mikus MD	
23B. DATE SIGNED 08-03-70		23C. PHYSICIAN'S NAME (Type) S. D. MIKUS MD	
23D. ADDRESS UMH		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 8/6/70		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park	
24D. LOCATION Baltimore		24E. STATE Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1970		25B. NAME OF REGISTRAR Robert E. Tabor, MD	
25C. FUNERAL DIRECTOR Robert C. Altenburg		25D. ADDRESS Funeral Home, Inc. 6009 Harford Rd. - Baltimore, Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 7831		REG. NO.	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HERBERT L. HESSON				2. DATE AND HOUR OF DEATH 8.4.70 7.52 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3603 N. Rogers Ave			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12.15.91	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery - Self Employed			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND, Carroll Co.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Hesson				
14. MOTHER'S MAIDEN NAME Hill			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				
16. SOCIAL SECURITY NO. 215-22-3496			17. INFORMANT H. GWINN Hesson ADDRESS 9726 Hillshire Rd. ELICOTT City, Md.				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 320.91 HYPERPYREXIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 2 DAYS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) MENINGITIS DUE TO, OR AS A CONSEQUENCE OF: DAYS (C) ASPIRATION PNEUMONIA 2 DAYS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CORONARY ATHEROSCLEROSIS							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8.2 1970 to 8.4 1970 that (I) (we) lost saw the deceased alive on 8.4 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE  CARLOS VICTOR ROZENBOM MD				23B. DATE SIGNED 8.4.70		23C. PHYSICIAN'S NAME (Type) CARLOS VICTOR ROZENBOM MD	
24A. BURIAL, CREMATION, ENTOMBMENT XXXXX		24B. DATE 8-7-70		24C. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Armacost Funeral Chapel-4600 Liberty Hts			

• Intermittent :

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- 1 -

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1-3-1

[illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7832</u>	
<div style="display: flex; justify-content: space-between;"> <u>L-251</u> <u>70 7832</u> CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <u>LEROY Le Compte</u>			2. DATE AND HOUR OF DEATH <u>8-2-70</u> <u>5</u> ^{<u>30</u>} <u>P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>37</u> <u>Mercy Hospital</u>			A. STATE <u>Maryland</u> B. COUNTY <u>102</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>273 S. Ellwood Avenue</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-9-21</u>	9. AGE (in years last birthday) <u>48</u>	10. If Under 1 Yr. Months: Days: Hours: Mins.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Elec. Mfg.</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Thomas J. LeCompte</u>			14. MOTHER'S MAIDEN NAME <u>Nettie Carroll</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates at service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>212-16-2733</u>	17. INFORMANT <u>Mrs. Patricia LeCompte</u>		ADDRESS <u>273 S. Ellwood Ave., Baltimore, Md.</u>
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
			<u>Cardiac arrest</u>		<u>seconds</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <u>Spreading carcinoma lung</u>		
			(C) <u>Pneumonia</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>7/21/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Mass lung</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/7/70</u> 19 <u>70</u> to <u>8/2/70</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>8/2/70</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M Clavel</u>				23B. DATE SIGNED <u>8/2/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>MANUEL CLAVEL</u>				23D. ADDRESS <u>MERCY HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-5-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 7 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Nicholas T. Matthews</u>	
				ADDRESS <u>2021 Eastern Ave., Baltimore, Md.</u>	

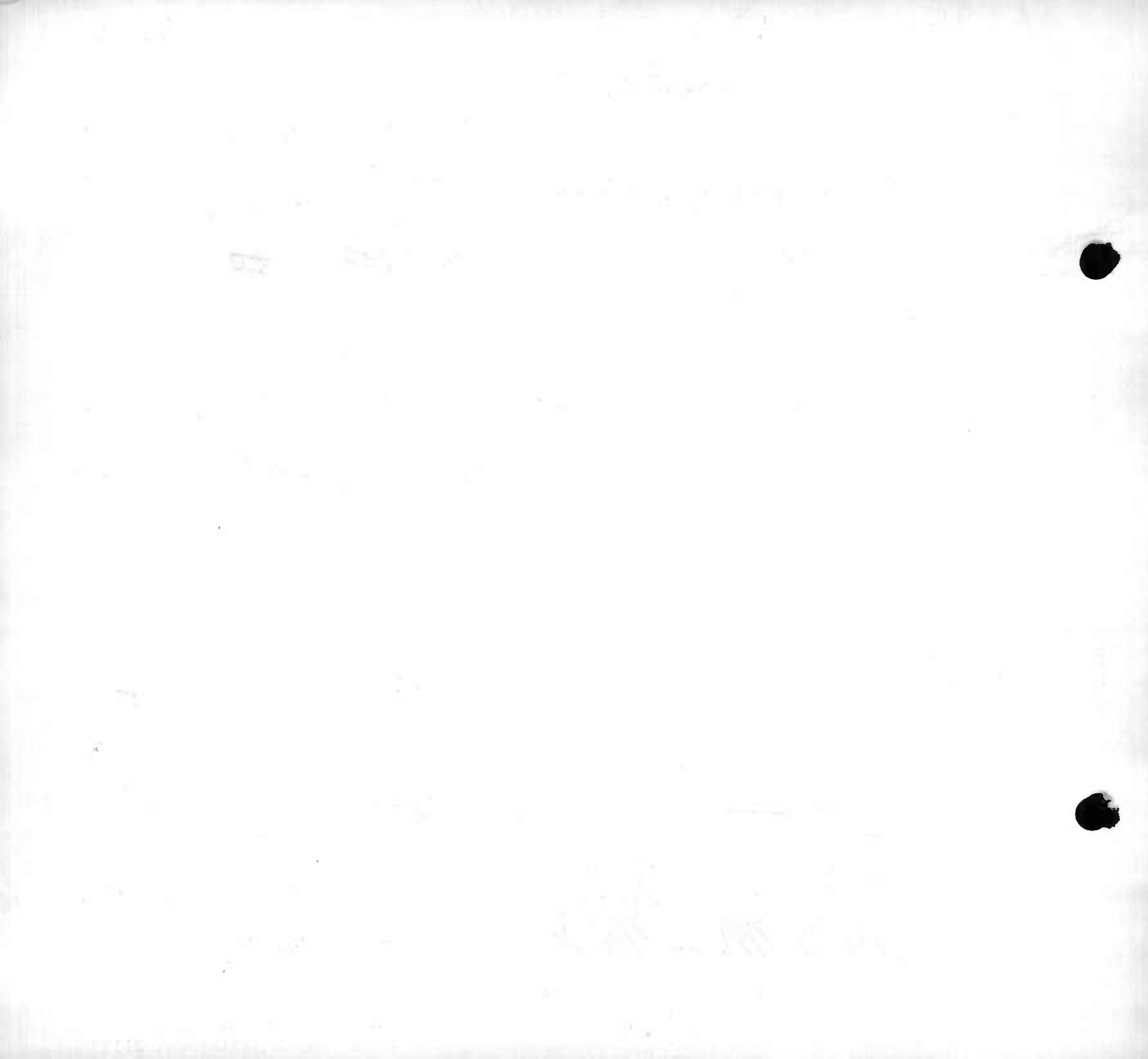
Print 8-2-50

Yes W.M. II 10-10-113 273 2 Edward A. B. 11-11-113
Thomas J. LeCompte
Foreman
Plate White
10-8-21 48
Maryland
Noetic Council
11-11-113 273 2 Edward A. B. 11-11-113
The Council
11-11-113 273 2 Edward A. B. 11-11-113

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

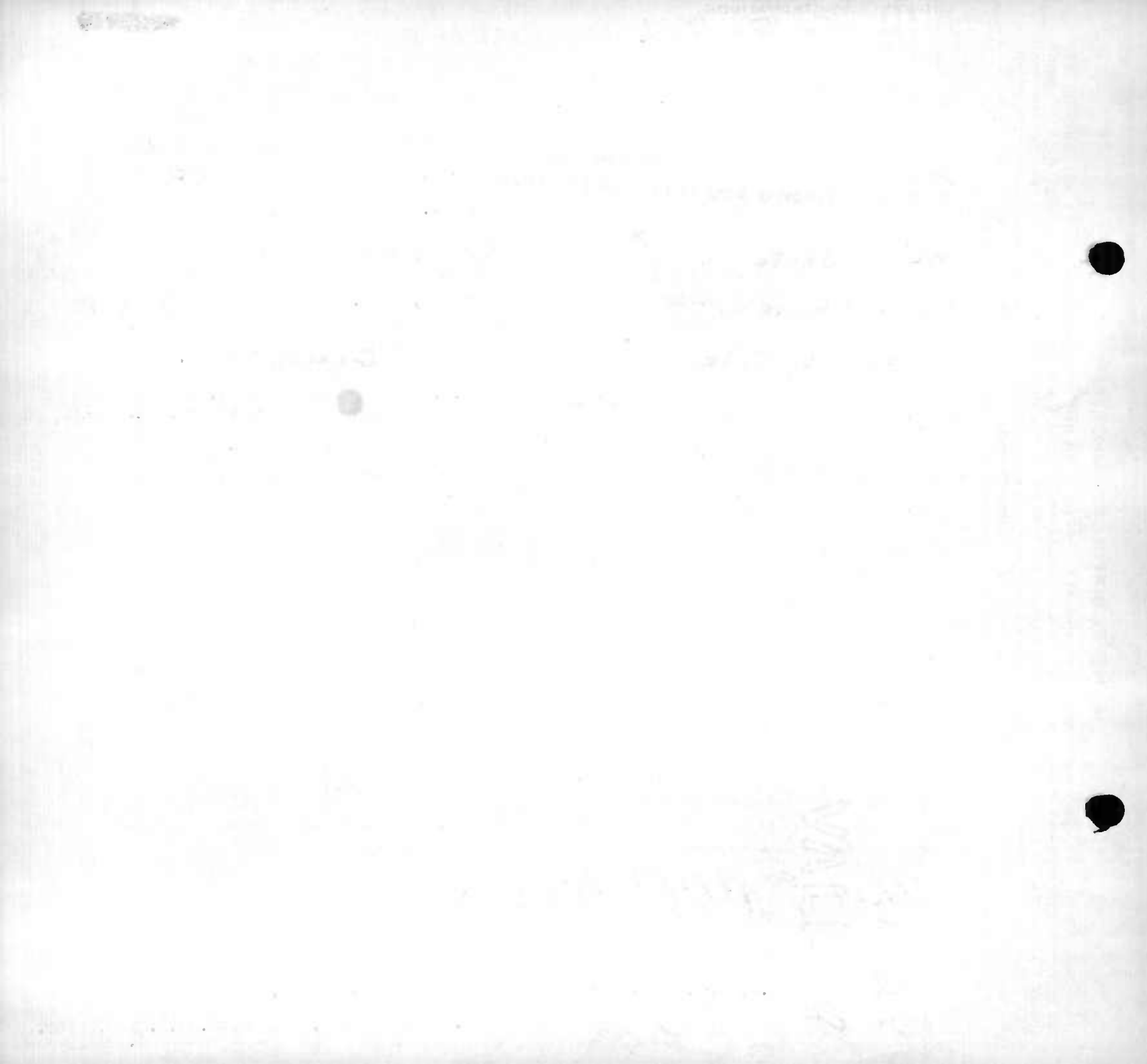
F-633 70 7833				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 7833	
1. NAME OF DECEASED (Type or Print) FERTITTA, FRANCO FILIPPO				2. DATE AND HOUR OF DEATH 8/5/70 5:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 42 Sinai Hospital of Baltimore				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore Co. C. CITY OR TOWN Randallstown D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3505 Templar Road			
5. SEX M		6. RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/02/28 9. AGE (in years last birthday) 41	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Coal Miner		10B. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Pasquale Fertitta				14. MOTHER'S MAIDEN NAME Concetta Cimino Fertitta			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-58-3223		17. INFORMANT Joseph Fertitta 3505 Templar Rd. Randallstown 21133			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE Carcinoma of prostate DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
				(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that he (this hospital) attended the deceased from 8/5 7/26 19 70 to 8/5 19 70 that (I) (we) last saw the deceased alive on 8/5 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Albert D. Munner M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8/5/70	
23C. PHYSICIAN'S NAME (Type) Albert D. Munner M.D. DEGREE				23D. ADDRESS 6215A Pimlico Rd. Baltimore			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/70		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cem.		24D. LOCATION (City, town, or county) (State) Liberty Rd. Balto. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Loring Byers Funeral Directors 8728 Liberty Rd. Randallstown, 21133			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. [REDACTED]	
C-400		70 7834		70 7834	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Charles Winkley Cole		8-3-70 - 6:30 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN		
Hood Convalescent Home Inc. 5313 Edmondson Ave. Balto. 21229			Md. Baltimore		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 101 W. Monument Street		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
male	White		6/5/1885	85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Provident Bank		Chauffeur		Boston, Mass.	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Samuel W. Cole			U. S. A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
No			215-03-1481		Mrs. E. Virginia Cole, 101 W. Monument Street Baltimore, Md. 21201
			14. MOTHER'S MAIDEN NAME		ADDRESS
			Green, Clara A.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Perforated Ulcer		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thos. J. Abbott M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		Aug. 6, 1970		Woodlawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 7 1970		Robert E. Taylor, Jr.		G. Truman Schwab, 5151 Balto. Nat'l. Pike, Balto., Md. 21229	
				ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

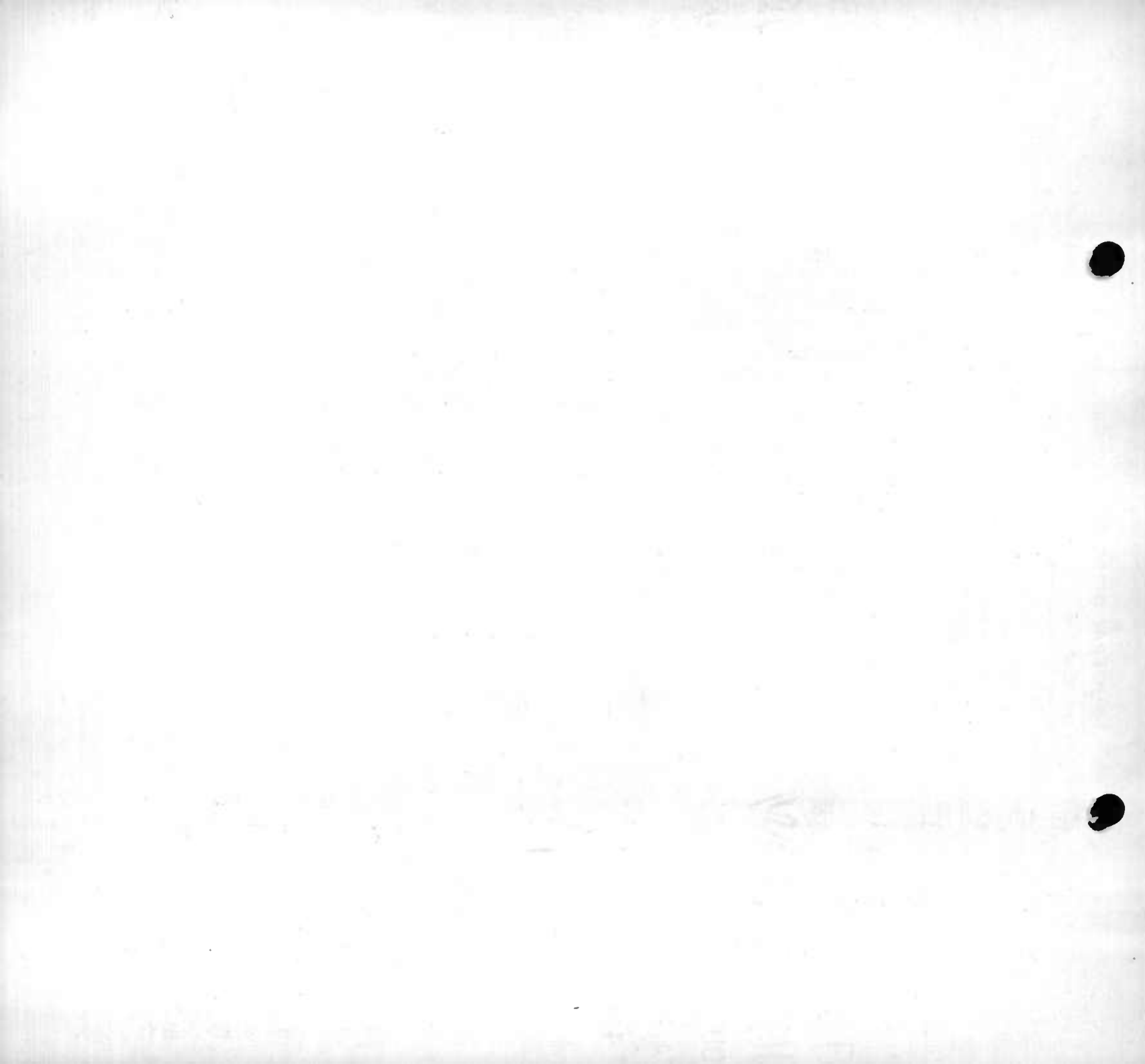
B-655 70 7835		BALTIMORE CITY HEALTH DEPARTMENT		70 7835	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Lillie A. Buhrman			August 2, 1970 7:00 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE		
			Maryland		
90 Gould Convalesarium			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			6110 Belair Road,		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 1, 1896	73	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
At home				Maryland	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Orlando Lee Smith			U.S.A. 7835		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
No					Mrs. Miriam Hopwood, 1319 S. Michigan Ave. Clearwater, Florida
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
<p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			Acute Cerebrovascular Accident		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			Proliferative Cerebrovascular Disease		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
			Old Hypertension, etc. from old stroke		
			Chronic Thrombophlebitis, left thigh.		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from 3/11/65 to 8/2/70 that (we) last saw the deceased alive on 8/1/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Albert B. Bradley				8/4/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Albert B. Bradley, M.D.				4900 Belair Road.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/5/70		Baltimore Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 7 1970		Robert E. [Signature]		Ulrich Funeral Home, 4210 Belair Road.	



FUNERAL DIRECTOR: IMPORTANT


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M-600 70 7836				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7836	
1. NAME OF DECEASED (Type or Print) JOHANNA MORAWE				2. DATE AND HOUR OF DEATH August 3, 1970 10 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Gould Convalesarium				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland 8. COUNTY 2757			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2826 Bauernwood Road			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 24, 1882	9. AGE (In years lost birthday) 88	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Schaefer				14. MOTHER'S MAIDEN NAME Knecht			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-5665		17. INFORMANT John Morawe, 2826 Bauernwood Road		ADDRESS	
18. 712.4 I 7-009.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septic C. V.D. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1953 to August 3, 1970 , that (I) (we) last saw the deceased alive on August 1, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE John Henry Haase M.D.				23B. DATE SIGNED August 3, 1970		23C. PHYSICIAN'S NAME (Type) J. Henry Haase M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/6/70		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Parkville, Md.	
25A. DATE PREP'D BY HEALTH DEPT. AUG 7 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Ullrich Funeral Home		ADDRESS 4210 Belair Road.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7837	
<div style="display: flex; justify-content: space-between;"> B-626 70 7837 70 7837 </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
George A. Burkhardt			August 4, 1970		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
44 Union Memorial Hospital			Maryland		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			4329 Harford Road,		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	June 28, 1893	77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Boilermaker			Railroad		New York, N.Y.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
George P. Burkhardt			Metcalf		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			705-03-6038		Geo. P. Burkhardt, 130 Club Road, Pasadena, Md.
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			minutes		
ANTECEDENT CAUSES			years		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			years		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Benign prostatic hypertrophy		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from March, 1949 19 to 8/4/70 19 that (I) (we) last saw the deceased alive on 7/28/70 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We, I, etc.) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				8/6/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
M. Friedman, M.D.				5211 Harford Road,	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		8/7/70		Parkwood Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 7 1970		Robert E. Fisher, M.D.		Ullrich Funeral Home. 4210 Belair Road.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

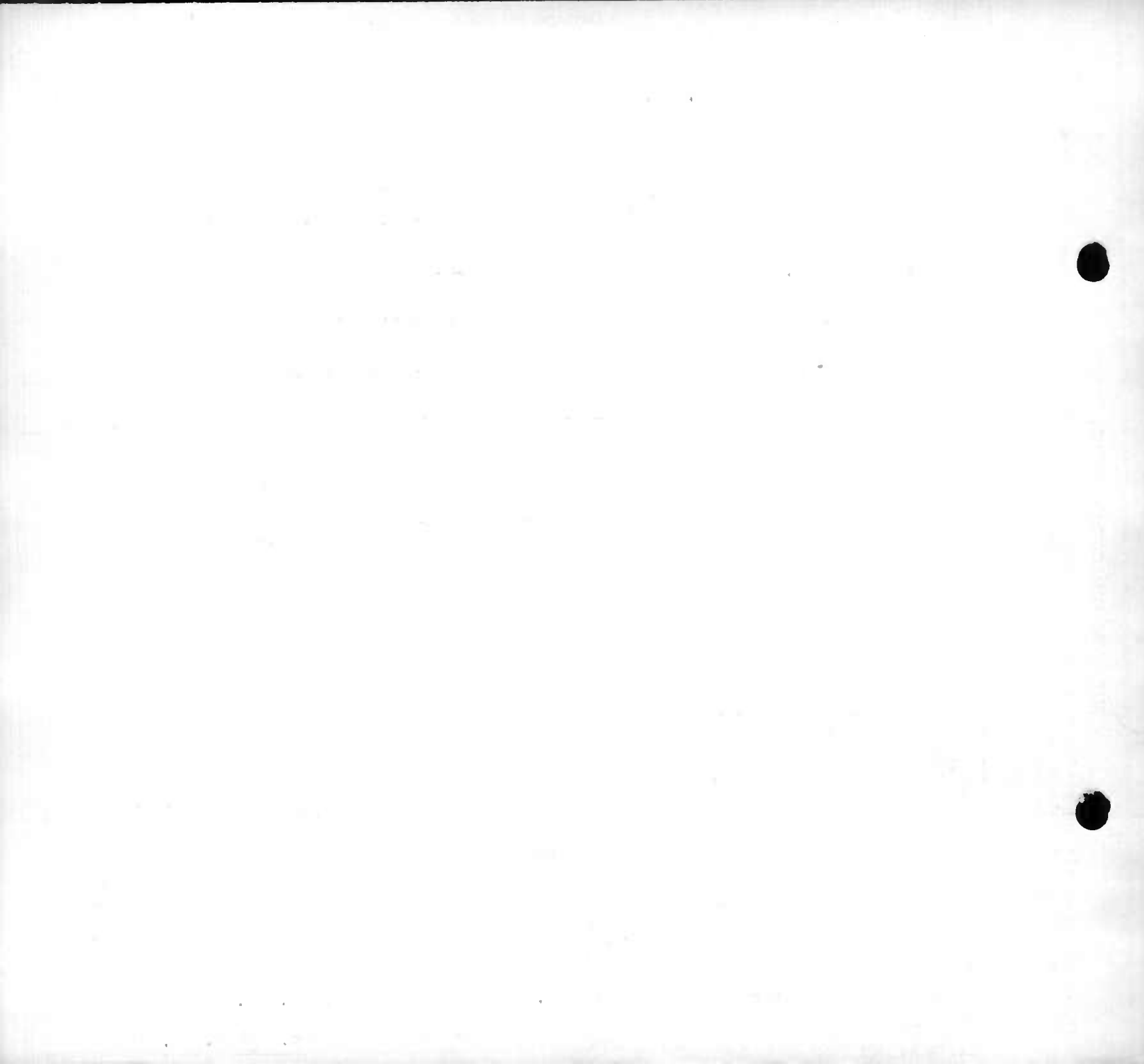
BIRTH NO. R-543		70 7838		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7838	
1. NAME OF DECEASED (Type or Print) JOSIAH BRINTON REYNOLDS				2. DATE AND HOUR OF DEATH July 31, 1970 7:55 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 927 N. Janney St., IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 2664 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 927 N. Janney St.,			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1887	9. AGE (In years last birthday) 82	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer			10B. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Penna/		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Tyson Reynolds			14. MOTHER'S MAIDEN NAME Sarah Mc Vey				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Bessie Reynolds 927 N. Janney St.,		ADDRESS
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebral arteriosclerosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 yrs.
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 19 61 to present 19 70 that (I) (we) last saw the deceased alive on July 31 19 76 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.							
23A. SIGNATURE H. F. Klinefelter				23B. DATE SIGNED 8/1/70		23C. PHYSICIAN'S NAME (Type) Harry F. Klinefelter, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/4/70		24C. NAME OF CEMETERY OR CREMATORY West Nottingham Cemetery		24D. LOCATION (City, town, or county) (State) Colora, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Ullrich Funeral Home, 4210 Belair Road.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 7839		REG. NO. 70 7839	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print)		TERRY W. Watson			2. DATE AND HOUR OF DEATH 8/4/70 8:15 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 901			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 MERCY Hospital				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 904 Chestnut Hill Ave 21218			
5. SEX Male	6. RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-3-44	9. AGE (In years last birthday) 26	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rug Cleaner		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Warren H Watson				14. MOTHER'S MAIDEN NAME Sophia L Eichelberger			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-40-4699		17. INFORMANT ADDRESS Mrs Judith A Watson 904 Chestnut Hill Ave			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH SUB-ARACHNOID. HARMORRAGIC DUE TO, OR AS A CONSEQUENCE OF: PROBABLY CONGENITAL BERRY ANEURYSM (Rupture) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from August 3rd 1970 to August 4th 1970 that (W) (we) last saw the deceased alive on August 4th 1970 and that (M) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (W) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Patrick A. Molony M.D.				23B. DATE SIGNED 8/4/70		23C. PHYSICIAN'S NAME (Type) PATRICK A. MOLONY M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-8-70		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1970		25B. NAME OF REGISTRAR Robert E. Jaber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

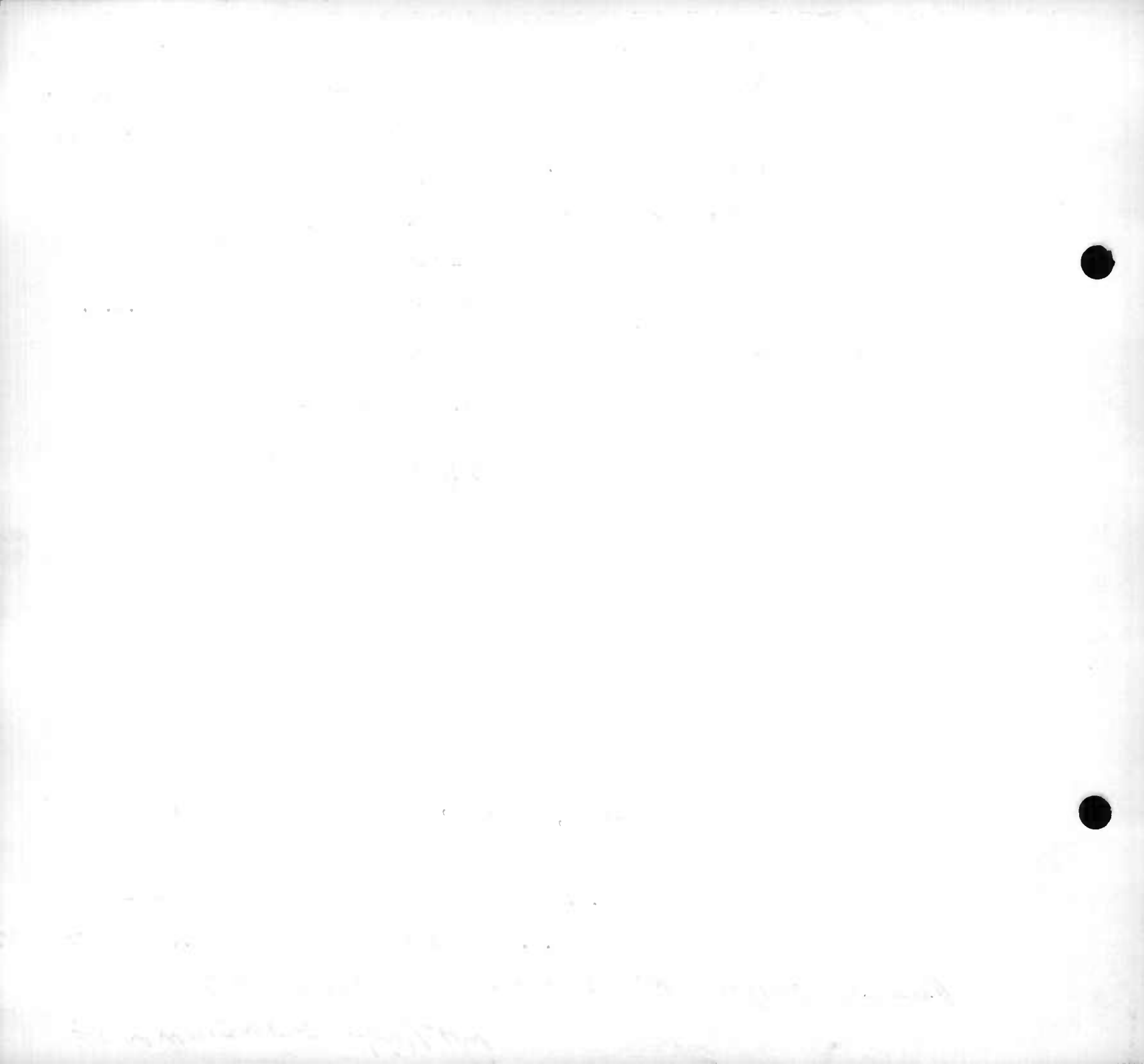
7-300 70 7840		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7840	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Lawrence Tate</i>		2. DATE AND HOUR OF DEATH <i>8-1-70 8:25 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2002</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>BON SECOURS HOSPITAL</i> <i>3425 W. FAYETTE ST.</i>		E. STREET AND NUMBER <i>2147 W. Saratoga St</i>			
5. SEX <i>male</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 6 1902</i>	9. AGE (In years last birthday) <i>68</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>JANITOR</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>W.C. POKER CO. 57 CHAPIN ST.</i>		11. BIRTHPLACE (State or foreign country) <i>GAFFNEY S.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Edward Tate</i>		14. MOTHER'S MAIDEN NAME <i>Mary Dowell</i>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Tate Family 627 Mount St</i>	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <i>Heart & respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF:		(B) <i>Carcinoma of larynx</i> DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-11</i> 19 <i>70</i> to <i>7-23</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>7-23</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>K. Zekry</i>		23B. DATE SIGNED <i>8/2/1970</i>		23C. PHYSICIAN'S NAME (Type) <i>KAMAL ZEKRY</i>	
23D. ADDRESS <i>BON SECOURS Hosp.</i>		23E. DATE <i>8/2/70</i>		23F. NAME OF CEMETERY or CREMATORY <i>GAFFNEY S.C.</i>	
23G. LOCATION (City, town, or county) (State)		23H. DATE REC'D BY HEALTH DEPT. <i>AUG 7 1970</i>		23I. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
23J. FUNERAL DIRECTOR <i>Maguire & Sons</i>		23K. ADDRESS <i>1014 m 18</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7841</u>	
BIRTH NO. <u>4-425</u>		70 7841		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Archie Holcombe</u>			2. DATE AND HOUR OF DEATH <u>7-31-70</u> <u>4:10 a.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1604</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital, Inc.</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>714 N. Fulton Avenue</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-11-12</u>	9. AGE (In years last birthday) <u>54</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Mark</u>		
14. MOTHER'S MAIDEN NAME <u>Mrs. Jones</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>no</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Julia Jones- Landlady</u>		ADDRESS <u>SAME</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE <u>Aspiration Pneumonia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Severe malnutrition</u> (C) <u>Severe malnutrition</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>7-31-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 23, 1970</u> to <u>July 31, 1970</u> that (I) (we) last saw the deceased alive on <u>July 31, 1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John G. Holm, M.D.</u>			23B. DATE SIGNED <u>7-31-70</u>		23C. PHYSICIAN'S NAME (Type) <u>John G. Holm, M.D.</u>
23D. ADDRESS <u>M.D. 1514 Division Street Balto., Maryland 21217</u>			24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>8/4/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>North Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 7 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>W. H. Jones</u>	
25D. ADDRESS		25E. ADDRESS			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7842

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Louis Gibson

2. DATE
OF
DEATHKnown ☐ Estimated ☐Month
8Day
1Year
70Hour
9:30

p. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital

3. DATE
PRONOUNCED DEADMonth
8Day
1Year
70Hour
9:30

p. M.

5. USUAL RESIDENCE (Where deceased lived, if Institution; residence before admission)

A. STATE

Md.

B. COUNTY

1501

6. SEX

male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

May 15 1923

10. AGE (in years
last birthday)

47

11. Under 1 Yr. 12. Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1555 N. Woodyear St.

11. BIRTHPLACE (State or foreign country)

BALTO MD

12. CITIZEN OF
WHAT COUNTRY?

MD

13. FATHER'S NAME

Louis S. Gibson

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Bertina Powell

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WWII

17. SOCIAL
SECURITY NO.

315-1845109

18. INFORMANT

James C. (Kron) 1458 N. Calvary St

ADDRESS

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Acute subdural hematoma

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

due to epileptic seizure with fall

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
yes22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)
xxxxx Home22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1557 N. Woodyear St.

22D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

9

30

70

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

subject was sitting
on steps and fell off.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

L. H. Conley

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/6/70

24C. NAME OF CEMETERY or CREMATORY

BALTO NATIONAL

24D. LOCATION (City, town, or county)

BALTO MD

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1970

25B. NAME OF REGISTRAR

J. E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Barbara P. Hays 638 N. 9th St

ADDRESS

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
W 452 70 7843		70 7843		3 ⁵⁰ P.M.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MARY F. Williams		7/31/70			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 38 University of Md.		A. STATE Md. B. COUNTY 2001			
		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 202 W. Monroo St			
5. SEX F	6. RACE N.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/13/22	9. AGE (In years last birthday) 48	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY 69 Home		11. BIRTHPLACE (State or foreign country) DETROIT-MICHIGAN	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Francis		14. MOTHER'S MAIDEN NAME Minnie F Smith	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.		16. SOCIAL SECURITY NO.		17. INFORMANT Charles Williams New York, N.Y.	
18. 23-0.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus (C) ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/31 19 70 to 7/31 19 70, that (I) (we) last saw the deceased alive on 7/31 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard A. Baum, MD		23B. DATE SIGNED 7/31/70		23C. PHYSICIAN'S NAME (Type) Richard A. Baum, MD	
23D. ADDRESS DEGREE		23E. FUNERAL DIRECTOR Wm. H. Hume 6844 Crum			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/5/70		24C. NAME OF CEMETERY or CREMATORY Arbuton Memorial P.R.	
24D. LOCATION (City, town, or county) (State) Baltimore 21227		25A. DATE REC'D BY HEALTH DEPT. AUG 7 1970		25B. NAME OF REGISTRAR Robert E. Fahey, M.D.	

Constitution
to the

James Madison
#2

James Madison
James Madison

James Madison

James Madison

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7844	
BIRTH NO. 4-620		70 7844	
1. NAME OF DECEASED (Type or Print) Harris, Melvin, Jr.		2. DATE AND HOUR OF DEATH 8-2-70 9:00P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital, Inc.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1602 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 705 N. Calhoun Street	
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-2-22
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blowman Operator/Corning		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 48
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Melvin Harris, Sr.		14. MOTHER'S MAIDEN NAME Jennie Smith	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-14-2456	
17. INFORMANT		ADDRESS Clark Smith 4A 555 N Mount St	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). atelectasis gastric ulcers with bleeding		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: mediastinitis, peritonitis 1 wk (B) anastomosis leak 1 wk (C) Ca of esophagus months	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 6-19 19 70 to 8-2 19 70 that (we) last saw the deceased alive on 8-2 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.			
23A. SIGNATURE J. SINGER		23B. DATE SIGNED 8/2/70	
23C. PHYSICIAN'S NAME (Type) J. SINGER		23D. ADDRESS MERCY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/2/70	
24C. NAME OF CEMETERY OR CREMATORY Mt Brown		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Merrill P. Hays		ADDRESS 138 N. Calhoun St	

1
6-000

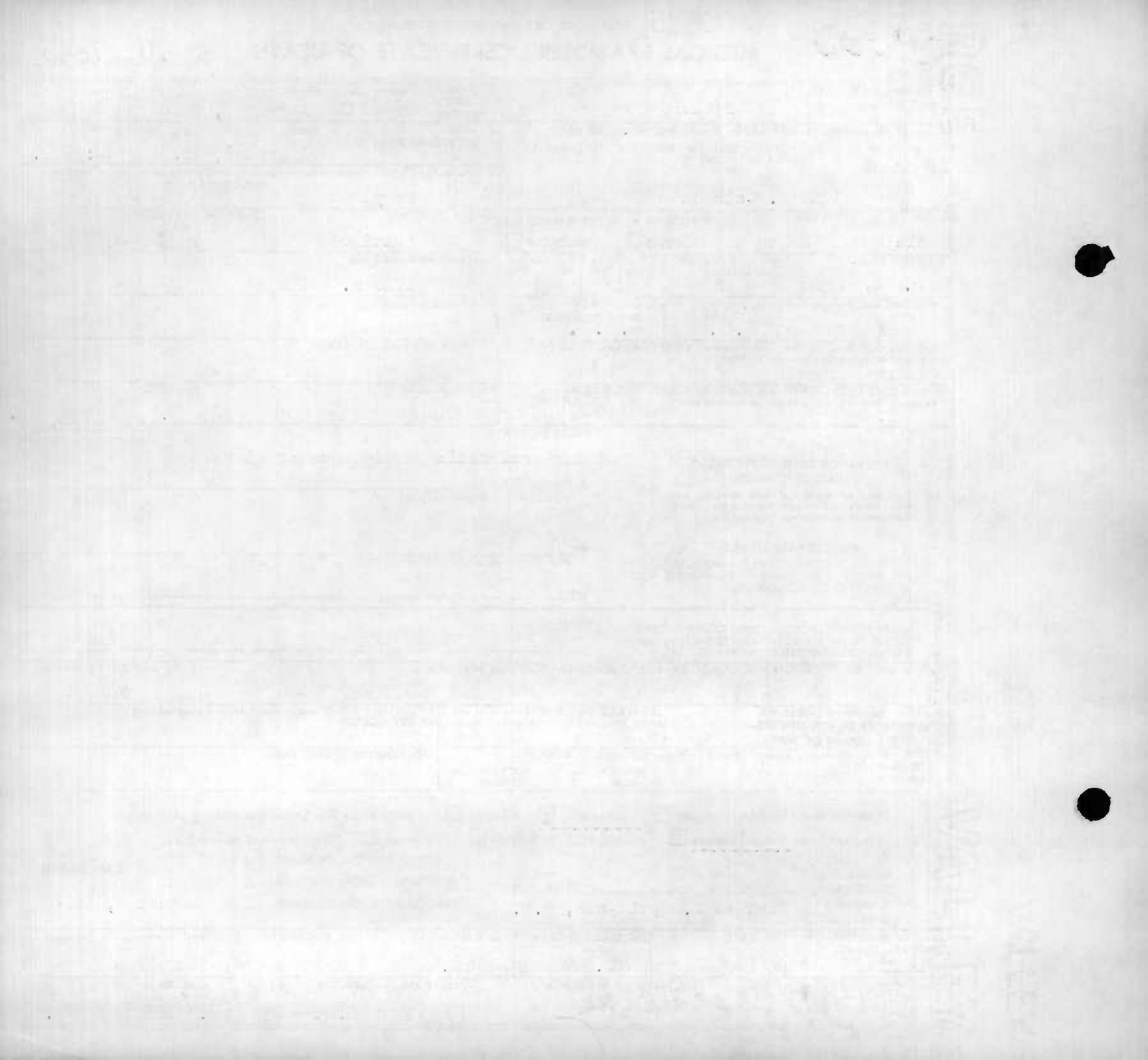
70 7845 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7845

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GUY SIPPO		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year August 5, 1970		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1729 N. Calhoun		3. DATE PRONOUNCED DEAD Month Day Year August 5, 1970		Hour 6:15 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland		B. COUNTY 1501			
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
9. DATE OF BIRTH Mar. 7, 1907		10. AGE (in years last birthday) 63		11. BIRTHPLACE (State or foreign country) Hollesville, N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Guy			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Venice	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unk.		17. SOCIAL SECURITY NO. 217-07-2329		18. INFORMANT Sarah Patterson	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 6, 1970					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/11/70		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1970		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.		25C. FUNERAL DIRECTOR Kelson F.H.	
ADDRESS 1348 N. Calhoun St.					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7846

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM CLARK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4104 Springdale Avenue		3. DATE PRONOUNCED DEAD Month Day Year August 4, 1970 5:15 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH May 10, 1911		10. AGE (In years lost birthday) 59 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Clark		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2802	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Sallie Smith		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W. II	
17. SOCIAL SECURITY NO. 101-18-2153		18. INFORMANT Roland Clark	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty Metamorphosis of Liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 8/7/70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes (Partial)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> (Partial) Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/5/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/10/70	
24C. NAME of CEMETERY or CREMATORY First United		24D. LOCATION (City, town, or county) (State) Gloucester Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1970 Robert E. Taylor, M.D.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR Kelson F.H.		25D. ADDRESS 1348 N. Calhoun St.	

ACADEMY BOND

NEW ORLEANS

MADE IN U.S.A.

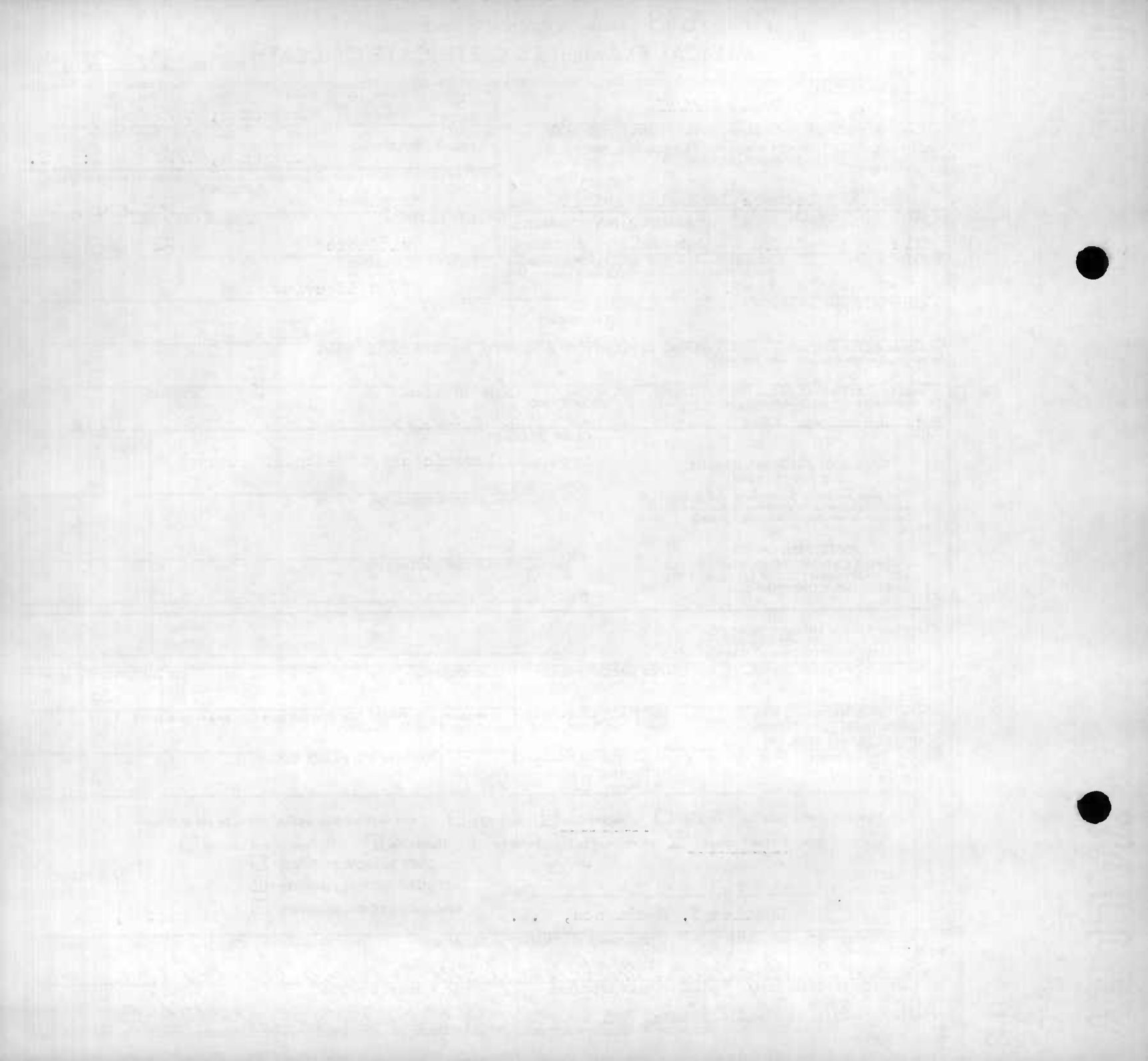
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7847</u>	
BIRTH NO. <u>B-260 70 7847</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>THOMAS BUCCHERI</u>		2. DATE AND HOUR OF DEATH <u>8/14/70 3:30 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals 21224</u>		A. STATE <u>Maryland</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4940 Eastern Avenue Baltimore, Maryland</u>		C. CITY OR TOWN <u>City of Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>6/14/99</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday) <u>71</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-36-0061A</u>		17. INFORMANT <u>4940 Eastern Avenue</u>	
18. <u>4/12/31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CHF</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>old ant MT</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>CCAD</u> <u>Diabetes mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 mos</u> <u>?</u> <u>new years</u>	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2/12/70</u> 19 <u>70</u> to <u>8/4</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>8/4/70</u> 19 <u>70</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>K. AFSARI</u>		23B. DATE SIGNED <u>8/14/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Khosrow Afsari</u>	
23D. ADDRESS <u>BCH</u>		23E. FUNERAL DIRECTOR <u>Ullrich Funeral Home. Dundalk. Md.</u>		23F. ADDRESS <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-7-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	
24D. LOCATION <u>Baltimore, Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>AUG 7 1970</u>		24F. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	

Page 2 of 2

1. NAME OF DECEASED (Type or Print) ISSAC BEATTY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> August 5, 1970		3. DATE PRONOUNCED DEAD Month Day Year August 5, 1970 Hour 11:10 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) (DOA) South Baltimore General Hospital		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2562		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 810 Bridgeview Road	
9. DATE OF BIRTH 6-8-93	10. AGE (In years last birthday) 77	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISSAC BEATTY		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		15. MOTHER'S MAIDEN NAME MARY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W.I		17. SOCIAL SECURITY NO. 220-059322		18. INFORMANT Elizabeth Beatty 8 Bridgeview Rd	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 8-12-70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED August 6, 1970 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Aug. 10, 1970		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel Coun. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 7 1970		25B. NAME OF REGISTRAR Robert E. Tabor, M.D.	
25C. FUNERAL DIRECTOR Calvin B. Scrubbs		25D. ADDRESS 1412 E. Preston St.			



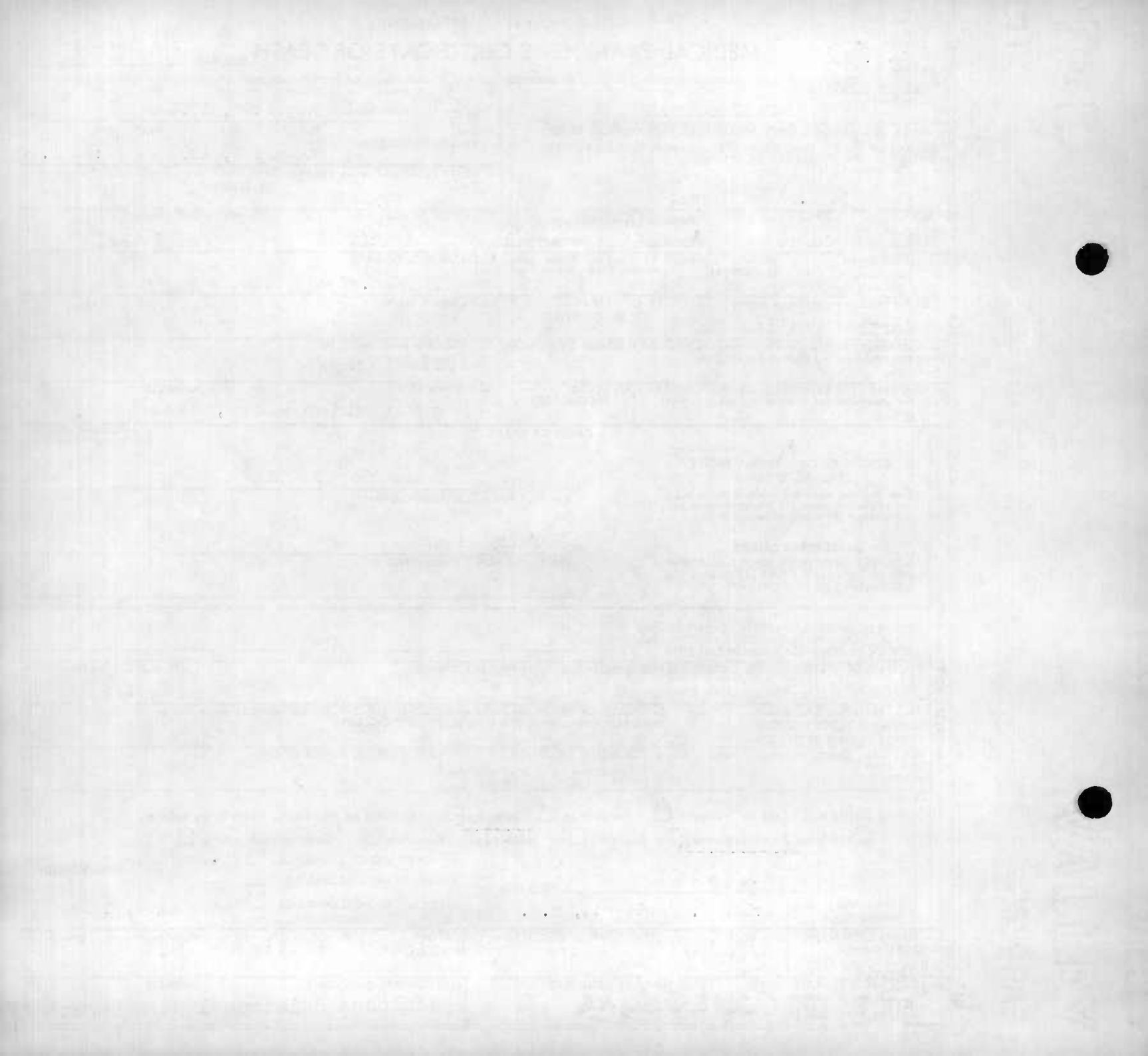
M-600

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JASPER MOORE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 5, 1970 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 24 N. Eden Street		3. DATE PRONOUNCED DEAD Month Day Year Hour August 5, 1970 7:00 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 301	
9. DATE OF BIRTH 7/27/23		10. AGE (in years last birthday) 46	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? A	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Lizzie Moore		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes WW 2	
17. SOCIAL SECURITY NO.		18. INFORMANT M's Catherine Moore, Same	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.		DATE SIGNED August 6, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/10/70	
24C. NAME OF CEMETERY OR CREMATORY Louden Park National		24D. LOCATION (City, town or county) (State) Baltimore M	
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W north AV	



FUNERAL DIRECTOR: IMPORTANT

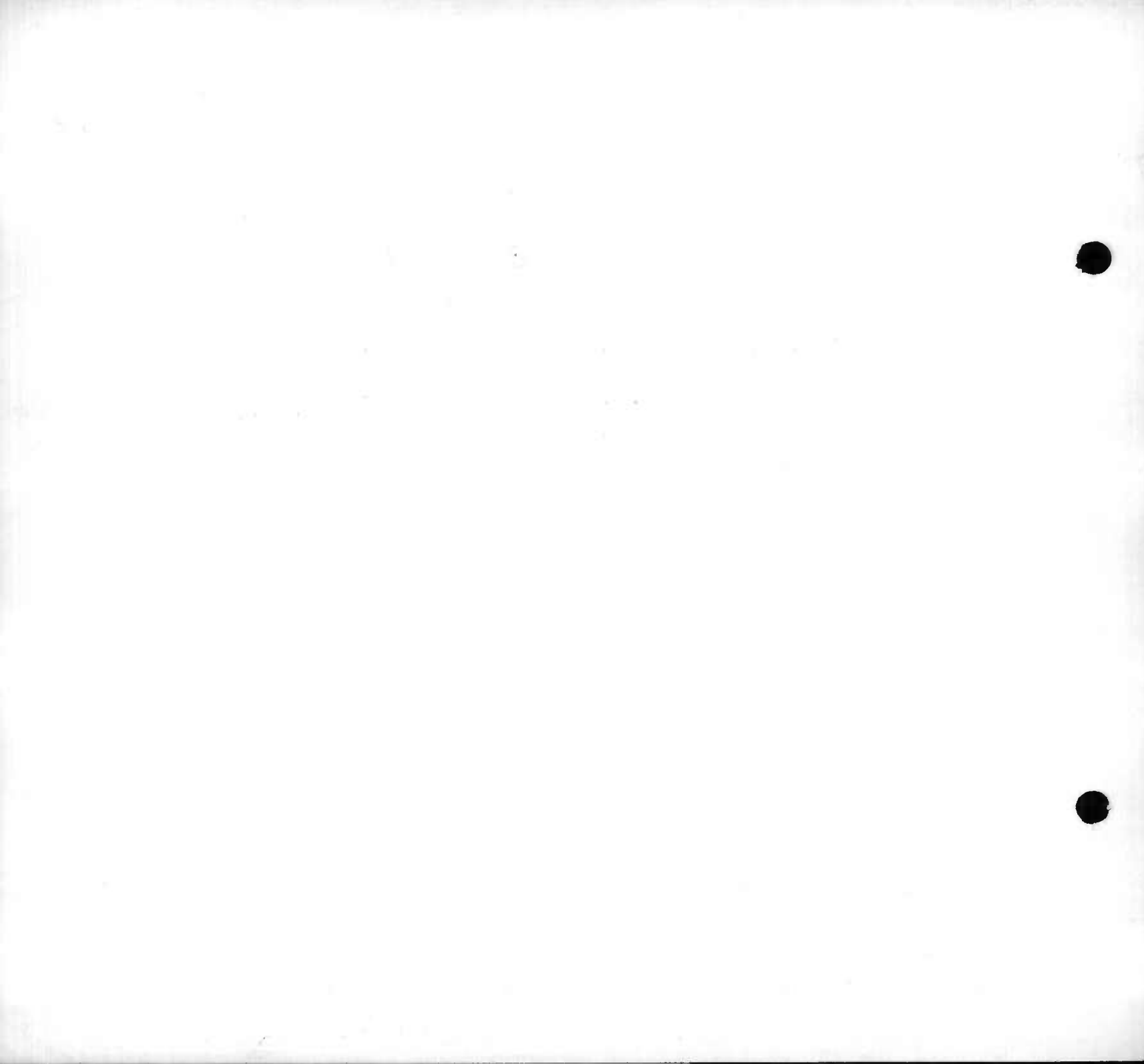
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452 70 7850		X		REG. NO. 70 7850	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Williams, Louise</u>		2. DATE AND HOUR OF DEATH <u>July 26, 1970</u> <u>6:13/A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>ANN</u>		C. CITY OR TOWN <u>Blen Burnie</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>		6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>8-26-95</u>		9. AGE (In years last birthday) <u>74</u>		(If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown DEPT STORE Unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown MARY ANDERSON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-14-3848</u>		17. INFORMANT <u>Baltimore City Hospitals</u> RECORDS: <u>4940 Eastern Ave. Balto., Md. 21224</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>SEPSIS</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>DIAB. MELITUS</u>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>5/17/70</u> <u>2/9/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>gynae</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (H) (this hospital) attended the deceased from <u>3-1</u> 19 <u>70</u> to <u>7-26-</u> 19 <u>70</u> , that (H) (we) last saw the deceased alive on <u>July 26</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Ronald Blum MD</u>		23B. DATE SIGNED <u>7/26/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Ronald Blum, M. D.</u> <u>Ronald Blum MD</u>	
23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>21224</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/30/70</u>	
24C. NAME OF CEMETERY or CREMATORY <u>MT CALVARY CEMETERY</u>		24D. LOCATION (City, town, or county) <u>CEAR HILL</u> <u>A. A. COUNTY, MD</u>		(State)	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 7 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>DONALD E. GLOVER</u> <u>1701 N. ATTERSON</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7851</u>	
70 7851 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>GEORGE A. HOWARD</u>		2. DATE AND HOUR OF DEATH <u>August 6, 1970</u> <u>4:15 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1512</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u> <u>33</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>3710 PARK HEIGHTS AVENUE</u>		
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> <u>DIVORCED</u>	8. DATE OF BIRTH <u>9/12/24</u>	9. AGE (In years last birthday) <u>46</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Noxell</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>GEORGE HOWARD SR.</u>		
14. MOTHER'S MAIDEN NAME <u>LYNN</u>			15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>28-14-0496</u>			17. INFORMANT <u>BERNICE FRIEND</u> ADDRESS <u>3503 SPRINGDALE</u>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMATOSIS</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Carcinoma of the Cecum</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>JULY 28</u> 19 <u>70</u> to <u>August 6</u> 19 <u>70</u> that (H) (we) last saw the deceased alive on <u>August 6</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert A. Adler, M.D.</u> DEGREE <u>M.D.</u>				23B. DATE SIGNED <u>August 6, 1970</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert A. Adler</u>				23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL, BALTIMORE, MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/10/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MTCALVARY CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>PI. ARUNDAI CO.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 7 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>DONALD E. GLOVER</u> ADDRESS <u>170 W. PATTERSON</u>	



3 Copies
T-460

70 7852

BALTIMORE CITY HEALTH DEPARTMENT

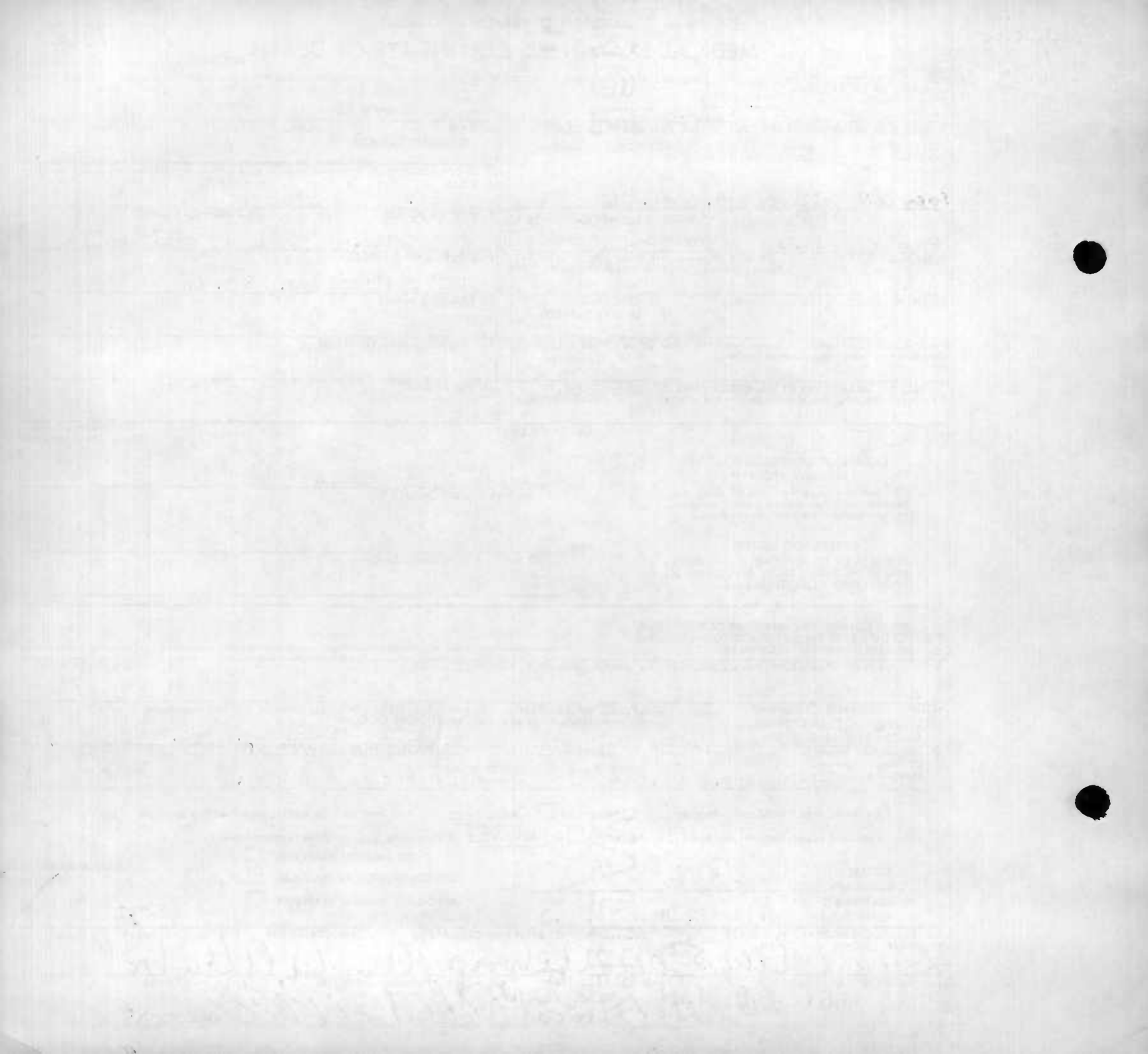
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 7852

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) LYNN LENORE TAYLOR		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1820 Guilford Ave. Apt. 2A		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 1 1970 10:30P.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Md. B. COUNTY 1205	
9. DATE OF BIRTH		10. AGE (In years lost birthday) 29	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes (head only)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID INJURY OCCUR? 1820 Guilford Ave. Apt. 2A		22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 8-1-70 app. 10 P.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot self in head.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-2-70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE AUG 5-70	
24C. NAME OF CEMETERY or CREMATORY Calvary Cem. A.A.B. Ind		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 7 1970		25B. NAME OF REGISTRAR Robert E. Williams	
25C. FUNERAL DIRECTOR Robert E. Williams		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 7853		REG. NO.	
BIRTH NO.				70 7853			
1. NAME OF DECEASED (Type or Print) <i>John McKethan</i>				2. DATE AND HOUR OF DEATH <i>8/4 9:45 AM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>33</i> <i>The Johns Hopkins Hospital</i>				A. STATE <i>Maryland</i>		B. COUNTY <i>808</i>	
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>1734 E. Eager Street</i>							
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>2/8/98</i>	9. AGE (in years last birthday) <i>72</i>	10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <i>Retired - Stenographer</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>unknown</i>				14. MOTHER'S MAIDEN NAME <i>unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Ronald Madley-2714 Denwick Ave</i>	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac Failure</i>		<i>2 d</i>	
				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Monilia Sepsis</i>		<i>10 d</i>	
				(C) DUE TO, OR AS A CONSEQUENCE OF: <i>Low Pressure Hydrocephalus</i>		<i>2 y</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>8/30</i> 19 <i>70</i> to <i>8/4</i> 19 <i>70</i> and that (I) (we) last saw the deceased alive on <i>8/4</i> 19 <i>70</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Michael H. Merson M.D.</i>				23B. DATE SIGNED <i>8/4/70</i>			
23C. PHYSICIAN'S NAME (Type) <i>Michael H. Merson, M.D.</i>				23D. ADDRESS <i>The Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/7/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>mt Auburn Cme</i>		24D. LOCATION (City, town, or county) (State) <i>Westport, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 7 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, R.D.</i>		25C. FUNERAL DIRECTOR <i>McDon C. Clifton 1129 N. Calver St</i>		ADDRESS	

70 7854 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO

70 7854

J-525		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 7854	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD	
Charles Johnson		Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> Month 8 Day 3 Year 70 Hour 5:45 p.m.		Month 8 Day 3 Year 70 Hour 5:45 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE	
33 Johns Hopkins Hospital		Md.		B. COUNTY 704	
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
male		Negro		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)	
Nov. 15, 1954		15		Maryland	
12. CITIZEN OF		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
WHAT COUNTRY		Eddie Johnson		Student	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
Evelyn Glass		no			
18. INFORMANT		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Evelyn Johnson - 913 N. Broadway		Multiple injuries			
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)	
0				no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Street		1000 blk. North Gay St. at Lamont	
22D. TIME (Month) (Day) (Year) (Hour) (Minute) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
8 3 70 5:10 p.m.				Subject was hit by Plymouth sta. wagon while operating a makeshift wagon.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Werner U. Spitz, M.D. Deputy Chief Medical Examiner		Removal		8/6/70	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.	
Burlington, N.C.		Burlington, N.C.		AUG 7 1970	
24F. NAME OF REGISTRAR		24G. FUNERAL DIRECTOR		24H. ADDRESS	
Robert E. Fisher, R.D.		John J. Clifton - 1129 N. Carolina			

ACADEMIC RECORD

10
N

Handwritten notes at the bottom of the page, including the date "April 1944" and other illegible text.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7855

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Stanley Cunningham

2. DATE OF DEATH

Known ☐ Estimated ☐

Month 8 Day 2 Year 70 Hour 12:35 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FOLIO NO. OF HOSPITAL OR INSTITUTION
ADDRESS OF LOCATION

1625 Miller Street 8-26-70

3. DATE PRONOUNCED DEAD

Month 8 Day 2 Year 70 Hour 12:35 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Md.

B. COUNTY

806

6. SEX

male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

12/9/60

10. AGE (In years last birthday)

9

11. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1711 N. Bradford Street

11. BIRTHPLACE (State or foreign country).

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Ida Cunningham

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Criste Lawrence 1711 N. Bradford

19.

1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Craniocerebral injuries

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

?

22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?

?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)

?

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ ~~Homicide~~ ☐ Undetermined manner ☒ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

8/3/70

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/1/70

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State)

Westport, Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 7 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, R.D.

25C. FUNERAL DIRECTOR

Milton E. Elchert 112971 Andrews

ADDRESS

Letter from M.E.'s office
8-26-70

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

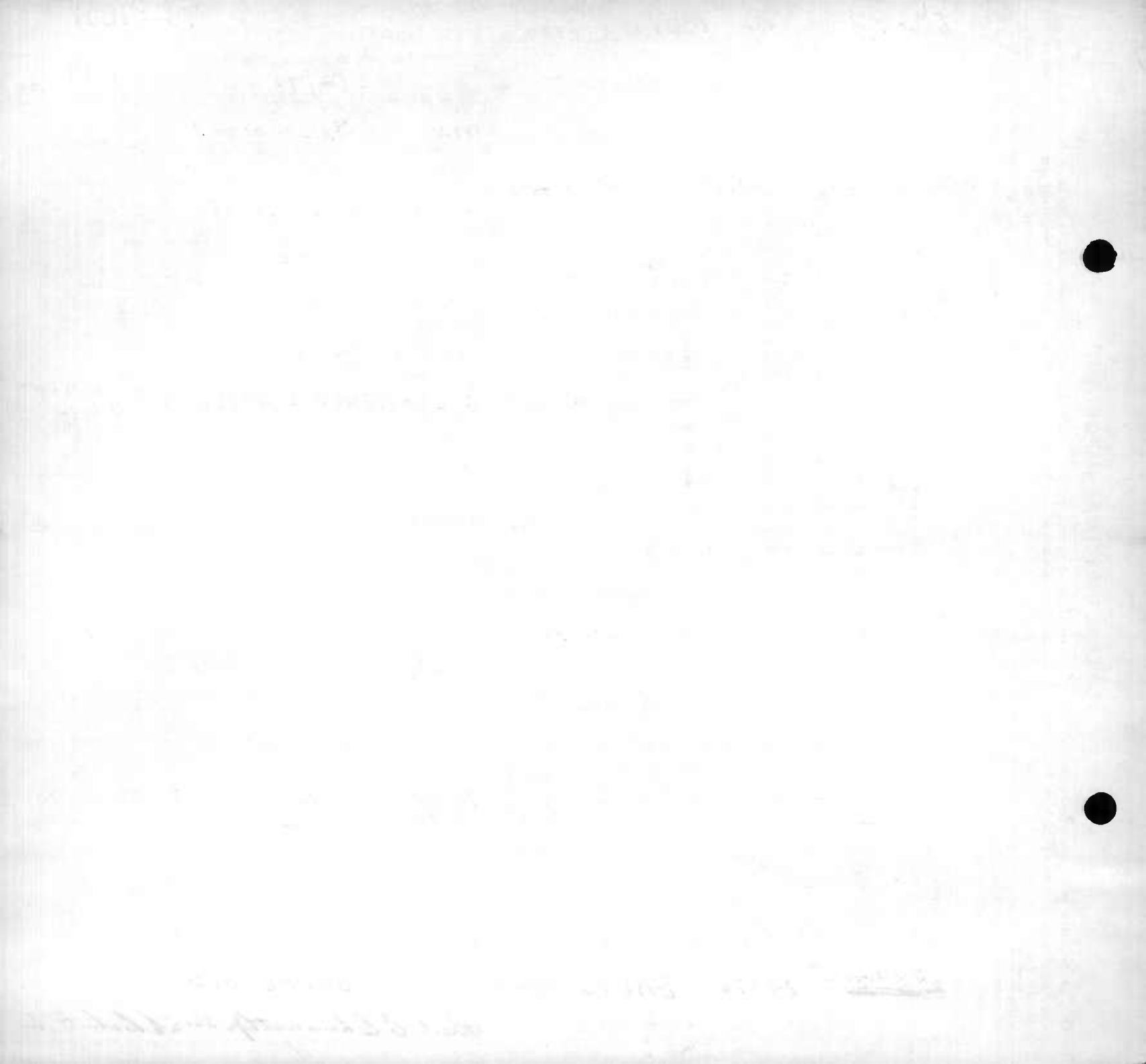
BIRTH NO. <u>L-200</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 7856</u>	
1. NAME OF DECEASED (Type or Print) <u>LEWIS, Joseph S.</u>				2. DATE AND HOUR OF DEATH <u>July 31st 1970</u> <u>7:45 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u>				A. STATE <u>MD</u>		B. COUNTY <u>1338</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3642 MALDEN AVE</u>			
5. SEX <u>male</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/17/96</u>	9. AGE (in years last birthday) <u>73</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATIONERY ENG.</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>DAIRY</u>		11. BIRTHPLACE (State or foreign country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>?</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u>			16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>WM N. LEWIS 1205 CRESTVIEW RD</u>		
18. <u>150X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Esophageal Ca.</u>			CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>about 5 months</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Esophageal Ca.</u>				
			(B) DUE TO, OR AS A CONSEQUENCE OF:				
			(C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>June 25th '70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>July 23rd 1970</u> to <u>July 31st 1970</u> that (I) (we) last saw the deceased alive on <u>July 31st 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Dr. Charles Lee M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>July 31st '70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Harry Bermen M.D.</u>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8-4-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE MEM.</u>		24D. LOCATION (City, town, or county) (State) <u>DORSEY MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Zuber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Paul E. Chumney</u>		ADDRESS <u>3615 Lakeland Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

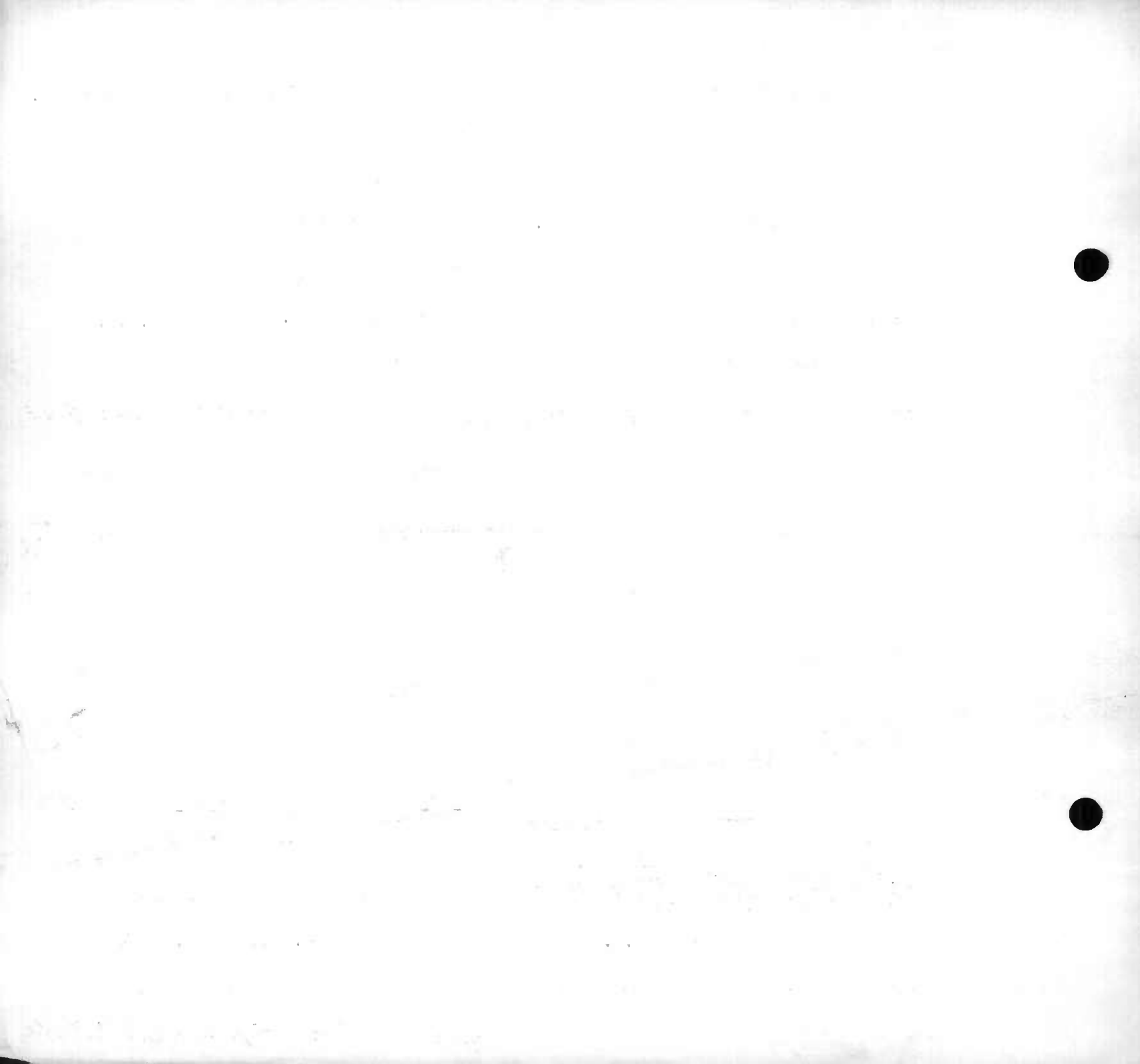
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-623 70 7857		BALTIMORE CITY HEALTH DEPARTMENT		X Registered No. 70 7857	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
BLANCHE W. ARSCOTT		8/2/70		1 7 ³⁵ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
MARYLAND GENERAL HOSPITAL		MD. BALTIMORE 5300			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		4412 ALAN DRIVE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
F	W	M	12-15-97	72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
BOOK KEEPER		BEVERAGE ASSO.		MARYLAND U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
JACOB PIERCE WOLFE		OLIVIA DAVIS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		216 05 5309		ST. CLARENCE L ARSCOTT 4412 ALAN DRIVE	
18. 15501		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) HEPATIC COMA			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		(B) HEPATOMA (?)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO			
		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		ASCVD	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
None				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 7-30 1970 to 8-2 1970, that (I) (we) last saw the deceased alive on 8-1 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
William O. Quesenberry M.D.				8-2-70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
WILLIAM O. QUESENBERRY		MARYLAND GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8-5-70		BALTO. NAT.	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
BALTO MD		AUG 10 1970		Robert E. Jaber, M.D.	
25A. FUNERAL DIRECTOR		25B. NAME OF REGISTRAR		25C. ADDRESS	
Paul E. Elchmann		Robert E. Jaber, M.D.		36156 Walnut Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

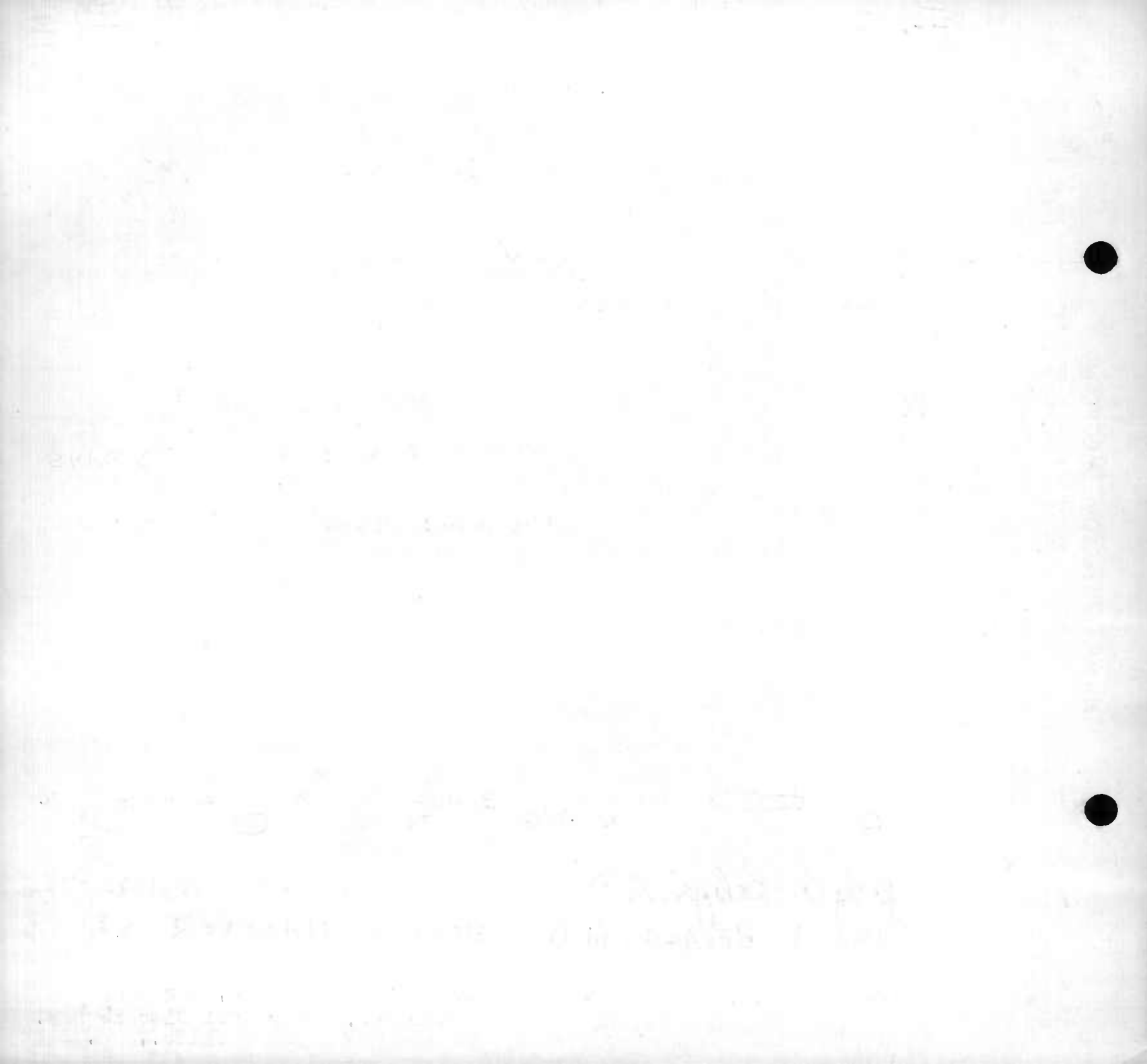
S-610 70 7858		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 7858	
1. NAME OF DECEASED (Type or Print) SHARP, Lester			2. DATE AND HOUR OF DEATH July 31, 1970 1:05 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 90 Bolton Hill Nursing & Convalescent Ctr. IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 401 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 612 East Pratt Street		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-5-97	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Harrison Sharp			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 235-05-3910		17. INFORMANT BETTY MAY 949 KIMWAT AVE
18. 43691 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) arteriosclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(A) IMMEDIATE CAUSE cerebro-vascular accident DUE TO, OR AS A CONSEQUENCE OF: arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years several yrs.
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-26-1968 to 7-31-1970 that (I) (we) last saw the deceased alive on 7-31-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE E. Ellsworth Cook DEGREE MD				23B. DATE SIGNED 7-31-70	
23C. PHYSICIAN'S NAME (Type) E ELLSWORTH COOK M.D. DEGREE				23D. ADDRESS 2431 Maryland Ave. Balto. Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/4/70		24C. NAME OF CEMETERY OR CREMATORY SHARPS	
24D. LOCATION (City, town, or county) MARLINTON W VA		24E. (State) VA		25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970	
25B. NAME OF FUNERAL HOME E. Ellsworth Cook		25C. FUNERAL DIRECTOR Paul E. Ellsworth ADDRESS 3615 Chestnut St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7859</u>	
F-652 <u>70 7859</u>		CERTIFICATE OF DEATH			
BIRTH NO.		DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>James B. Franklin</u>		8-4-70 3 ⁴⁰ P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u> <u>43</u>		A. STATE <u>Maryland</u>		B. COUNTY <u>2544</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>905 Washburn Ave</u>			
5. SEX <u>m</u>	6. RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7-24-06</u>	9. AGE (In years last birthday) <u>64</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>FIREMAN</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William W.C. Franklin, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Edith Barker</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217140595</u>		17. INFORMANT <u>HOSPITAL CHART</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>CORONARY THROMBOSIS</u> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ATHERO SCLEROSIS</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>YEARS</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>3 AUG 1970</u> to <u>4 AUG 1970</u> , that (I) <u>we</u> last saw the deceased alive on <u>4 AUG 1970</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Gary A. Belaga, M.D.</u>		23B. DATE SIGNED <u>4 AUG '70</u>		23C. PHYSICIAN'S NAME (Type) <u>GARY A. BELAGA, M.D.</u>	
23D. ADDRESS <u>3001 S. HANOVER ST.</u>		24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>8/8/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Elkridge, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>George J. Gonce</u>	
				ADDRESS <u>4001 Ritchie Hgy. Balto., Md. 21225</u>	



FUNERAL DIRECTOR: IMPORTANT

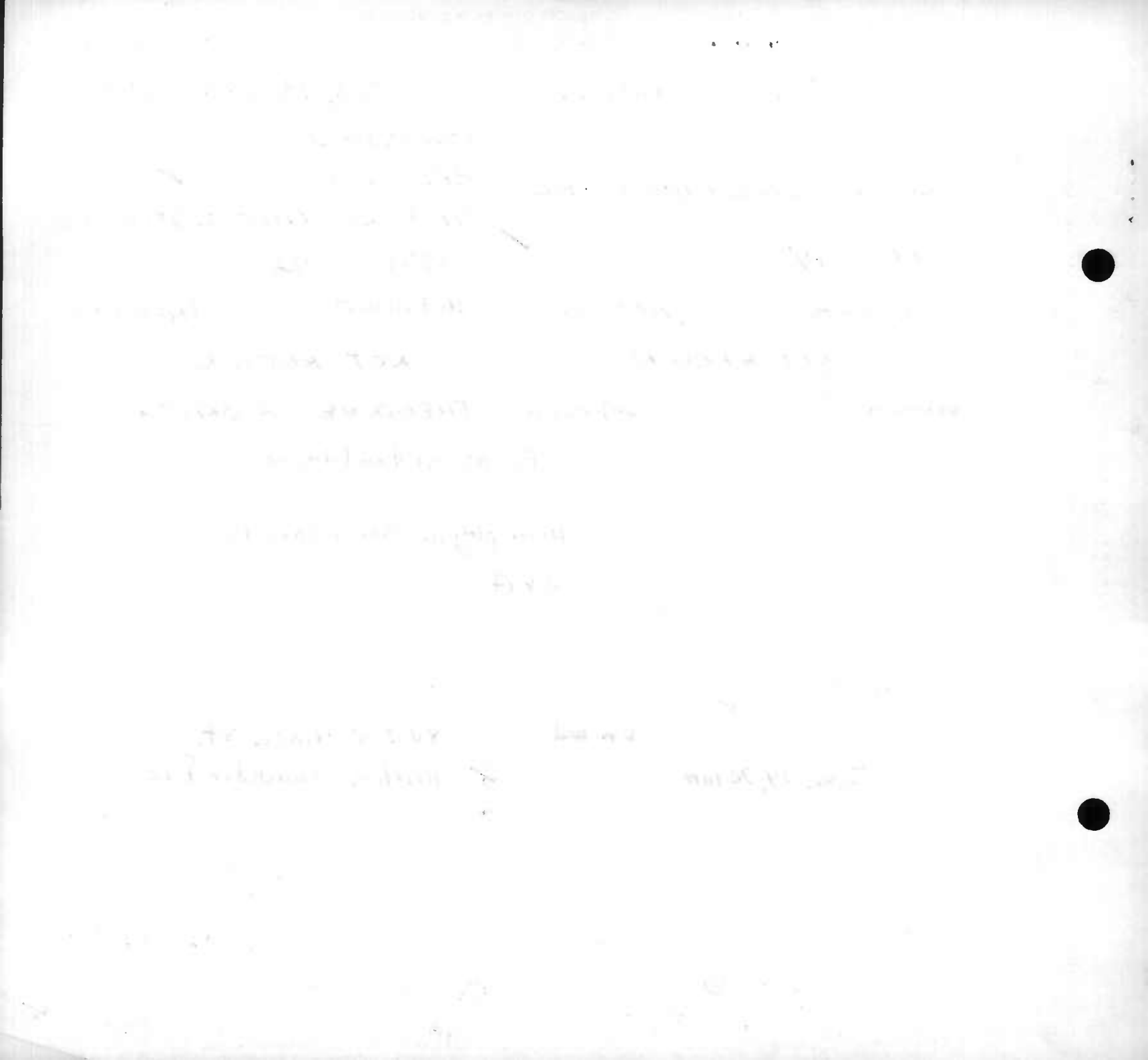
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
17-260		70 7860		70 7860	
1. NAME OF DECEASED (Type or Print) <u>Charles C. McGuire, Sr.</u>			2. DATE AND HOUR OF DEATH <u>3 AUGUST 1970 11:15 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Such Baltimore General Hospital</u> <u>43</u>			A. STATE <u>Maryland</u> B. COUNTY <u>2544</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>Male</u>			E. STREET AND NUMBER <u>807 Pontiac Avenue</u>		
6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-11-07</u>	
9. AGE (In years last birthday) <u>62</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Shipfitter</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Construction #438</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank McGuire</u>			14. MOTHER'S MAIDEN NAME <u>Catherine Halligan</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>216 05 4022</u>		
17. INFORMANT <u>Married wife</u>			ADDRESS <u>807 Pontiac Avenue</u>		
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>CORONARY THROMBOSIS</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ATHEROSCLEROSIS</u> CHRONIC OBSTRUCTIVE AIRWAY DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>YEARS</u>					
19. DATE OF OPERATION <u>8-2</u>			20. AUTOPSY? (Yes or No) <u>NO</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>8-2</u> 19 <u>70</u> to <u>3 AUG</u> 19 <u>70</u> that (I) <u>(we)</u> last saw the deceased alive on <u>3 AUG</u> 19 <u>70</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>G.A. Belaga, M.D.</u>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <u>GARY A. BELAGA M.D.</u>			23D. ADDRESS <u>3001 S. HANOVER ST</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>8/7/70</u>		
24C. NAME OF CEMETERY or CREMATORY <u>Holy Cross</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1970</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		
25C. FUNERAL DIRECTOR <u>George J. Gonce</u>			ADDRESS <u>4001 Ritchie Hwy. Baltimore, Md. 21225</u>		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

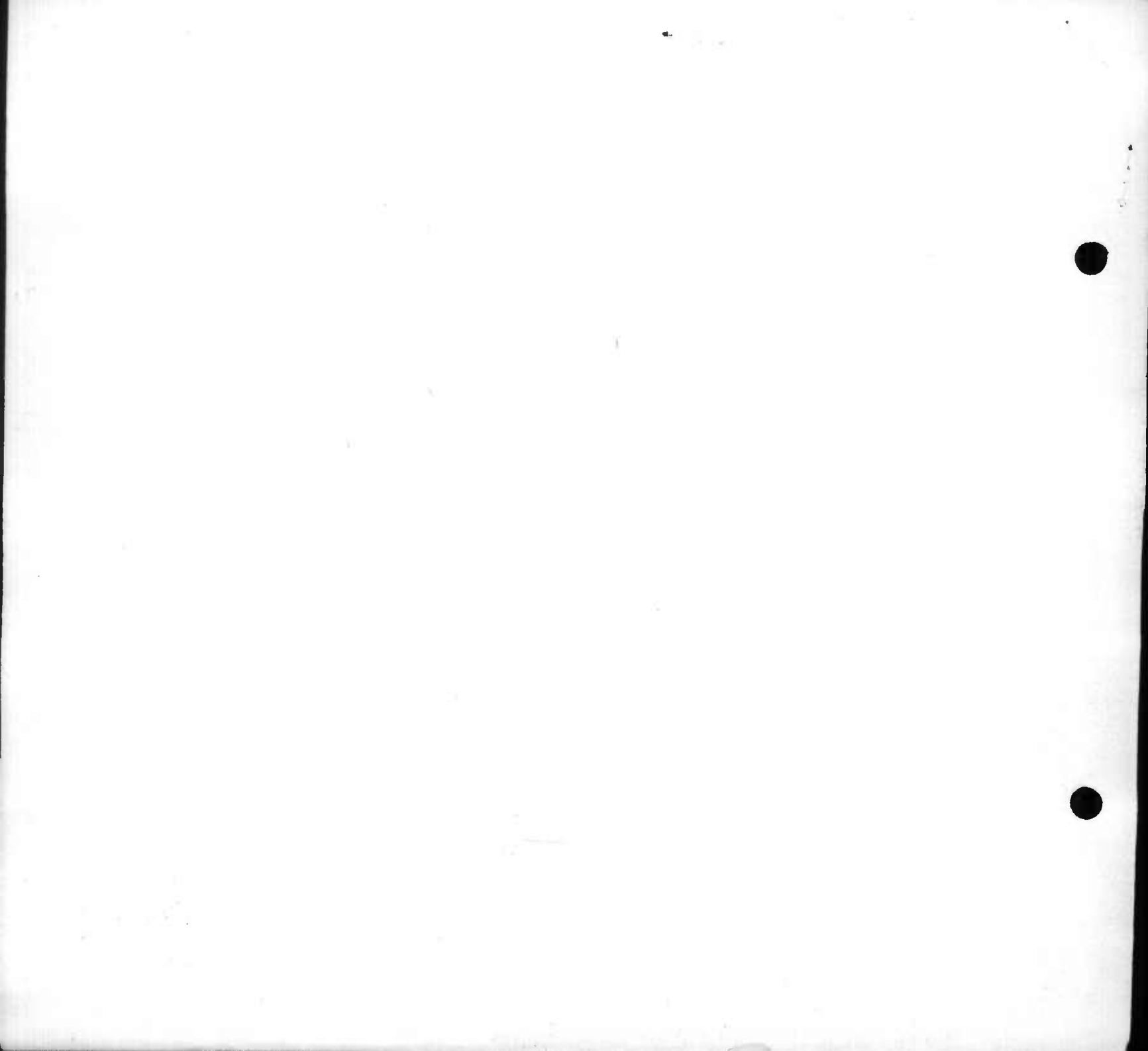
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 7861</u>	
S-354 70 7861		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>JOSEPH STANLEY</u>		2. DATE AND HOUR OF DEATH <u>July 19, 1970 3:25 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>CHURCH HOME + HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>302</u>	
		C. CITY OR TOWN <u>BALTIMORE</u>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>811 E. Baltimore St. 21202</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1898</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>HOTEL</u>	9. AGE (In years lost birthday) <u>72</u>
11. BIRTHPLACE (State or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME <u>NOT KNOWN</u>		14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT ADDRESS <u>THEODORE R. SMITH</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>EXP 981 X</u> <u>Burns, 1st & 2nd degree</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hemiplegia secondary to</u>	
		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>CVA</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <u>6-26-70</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>In bed</u>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>811 E. Baltimore St. 03-02</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>June 24, 70 1am</u>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>Mattress caught on fire</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>6-24-1970</u> to <u>7-19-1970</u> that (I) (we) last saw the deceased alive on <u>7/19/70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>T. Sree Ramamurthy</u>		23B. DATE SIGNED <u>7/19/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>T. SREE RAMAMURTHY</u>		23D. ADDRESS <u>CHURCH HOME + HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <u>8-6-70</u>	24C. NAME OF CEMETERY OR CREMATOR	24D. LOCATION (City, town, or county) (State) <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1970</u>	25B. NAME OF REGISTRAR <u>Robert E. Fisher, R.D.</u>	25C. FUNERAL DIRECTOR ADDRESS <u>MORTUARY SERVICE - BCHO</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

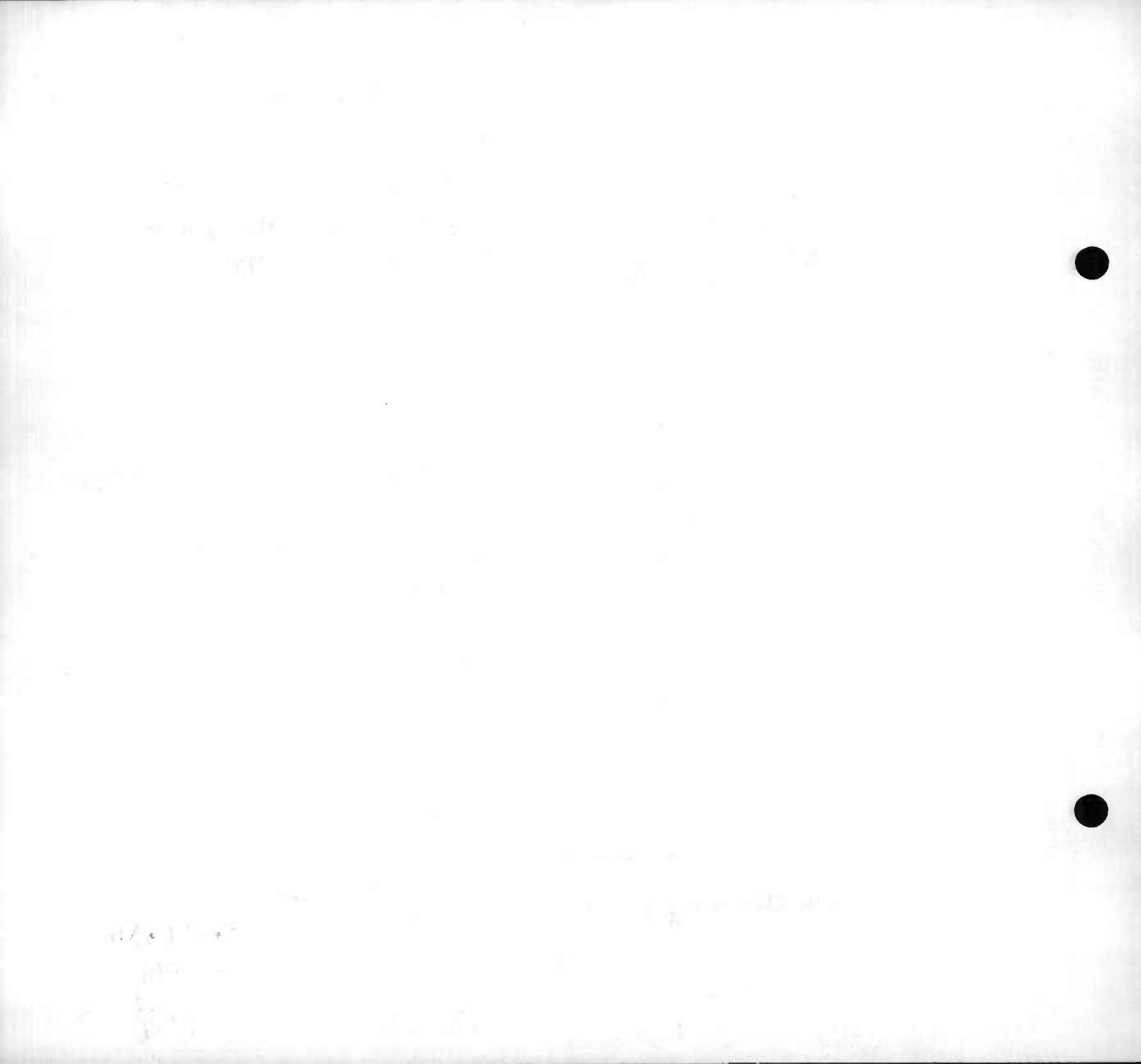
C-450		70 7862		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7862	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LEO JOSEPH CALLAHAN				2. DATE AND HOUR OF DEATH July 22, 1970 10605 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 1902			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ. of Md. Hospital				C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1400 Hollins St.			
5. SEX M	6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/17/88		9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Nellie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital chart. ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial infarction				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Dissecting aneurysm of aorta		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. fracture (L) femoral neck.				(B) DUE TO, OR AS A CONSEQUENCE OF: fracture (L) femoral neck.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 7-11-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED in section of Rustin-Moore		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1400 Hollins St.			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 7-11-70 ?		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell off ladder			
22. I certify that (I) (this hospital) attended the deceased from July 11, 1970 to July 22, 1970 and that (I) (we) last saw the deceased alive on July 22, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Frederick Pearson MD				23B. DATE SIGNED July 22, 1970		23C. PHYSICIAN'S NAME (Type) FREDERICK PEARSON, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8-6-70		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, county, state) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

S-530 70 7863		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7863	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Smith, James</u>		2. DATE AND HOUR OF DEATH <u>7-29-70</u> <u>9:30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1548</u>		5. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <u>M</u>		7. RACE <u>N</u>		8. DATE OF BIRTH <u>unknown</u>	
9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		10. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <u>77</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <u>Citizen of USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>412.4 1-197.8</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>ASVD</u> (A) IMMEDIATE CAUSE <u>unknown</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>A SCVD anemia, thrombophlebitis 20 days</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>liver dis. possibility of occult CA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 2, 1970</u> to <u>July 29, 1970</u> that (I) (we) last saw the deceased alive on <u>July 29, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Marcia Waterbury, M.D.</u>		23B. DATE SIGNED <u>7-29-70</u>		23C. PHYSICIAN'S NAME (Type)	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>8-7-70</u>		24C. NAME OF CEMETERY or CREMATOR	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u> <u>MORTUARY SERVICE - BCHD</u>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		X		70 7864	
S-300		70-12597-70		7864	
BIRTH NO.		70-12597-70		7864	
1. NAME OF DECEASED (Type or Print)		BO. Catherine Scott		BABY BOY SCOTT	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		6. DATE AND HOUR OF DEATH 7-27-70 6:40 P. M.	
FULL NAME OF HOSPITAL OR INSTITUTION 39		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital 1514 Divison Street Baltimore, Maryland 21217		Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7-17-70		9. AGE (In years last birthday) 10		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) Balto.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Catherine Scott		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Catherine Scott-Mother		ADDRESS Same		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Hypernatremia & Hypoxia	
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) none		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? none	
22. I certify that (I) (this hospital) attended the deceased from 7-17-70 to 7-27-70 that (I) (we) last saw the deceased alive on 7-27-70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Kok-Seah Lee, M.D.		23B. DATE SIGNED July 30, 1970	
23C. PHYSICIAN'S NAME (Type) KOK-SEAH LEE, M.D.		23D. ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL		24A. BURIAL CREMATION, REMOVAL (Specify) 8-6-70	
24B. DATE 8-6-70		24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	

called Hospital. address is
Bronx New York

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7865</u>	
BIRTH NO. <u>W-350 70 7865</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>BABY GIRL WHITNEY</u>			2. DATE AND HOUR OF DEATH <u>7/30/70</u> <u>12¹⁸</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>PROVIDENT HOSPITAL</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2102</u>		
			C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>1317 BAYARD ST.</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/29/70</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>RUSSEL COHEN</u>			14. MOTHER'S MAIDEN NAME <u>JACKIE WHITNEY</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MOTHER</u> ADDRESS <u>SAME</u>	
18. <u>776.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY IMMATUREITY</u> ANTECEDENT CAUSES <u>PREMATURE 24-26 WK GESTATION</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7-29-1970</u> to <u>7-30-1970</u> that (I) (we) last saw the deceased alive on <u>7-30-1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Felix L. Kaufman MD.</u> DEGREE				23B. DATE SIGNED <u>7-29-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>FELIX L. KAUFMAN M.D.</u> DEGREE				23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u> <u>BALTO. MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>8-6-70</u>		24C. NAME OF CEMETERY or CREMATORY	
				24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u> ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

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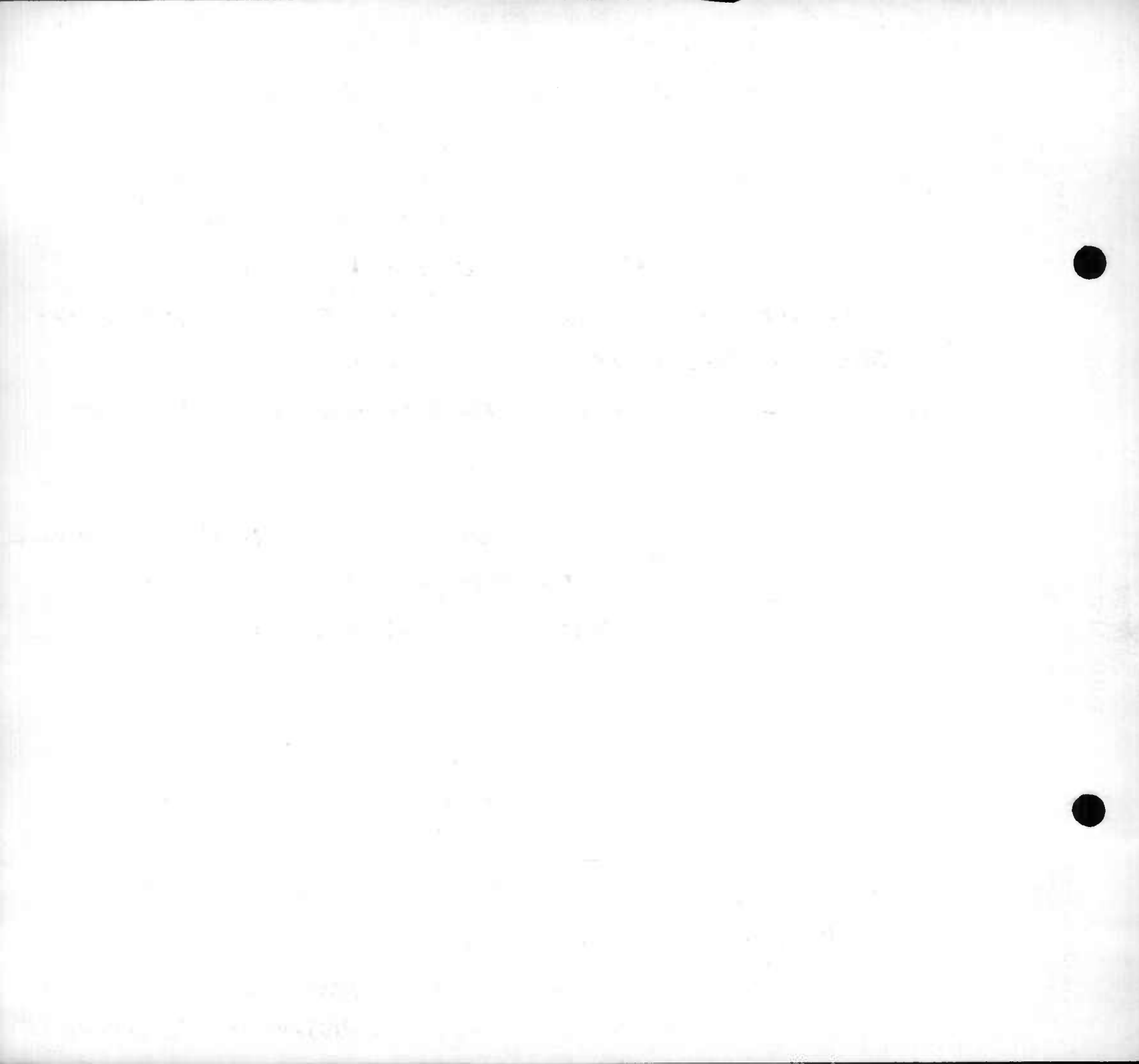
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7866 4	
J-520 70 7866		BIRTH NO. 70-13237			
1. NAME OF DECEASED (Type or Print) BABY GIRL JONES, EVELYN			2. DATE AND HOUR OF DEATH 7/29/70 11 55 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) PROVIDENT HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2717		
5. SEX F			6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 7/29/70	9. AGE (In years last birthday) 1 0
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME EVELYN C. JONES KNOTT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS EVELYN C. JONES SAME	
18. 259.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIO RESPIRATORY ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PREMATURITY			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). POSS. MONGOLISM & CONGENITAL HEART DIS.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-29 19 70 to 7-29 19 70 that (I) (we) last saw the deceased alive on 7-29 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Felix L. Kaufman M.D. DEGREE				23B. DATE SIGNED 7-29-70	
23C. PHYSICIAN'S NAME (Type) FELIX L. KAUFMAN MD. DEGREE				23D. ADDRESS ANATOMY BOARD OF MARYLAND MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 8-6-70		24C. NAME of CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Jaber, M.D.		25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCD	



FUNERAL DIRECTOR: IMPORTANT

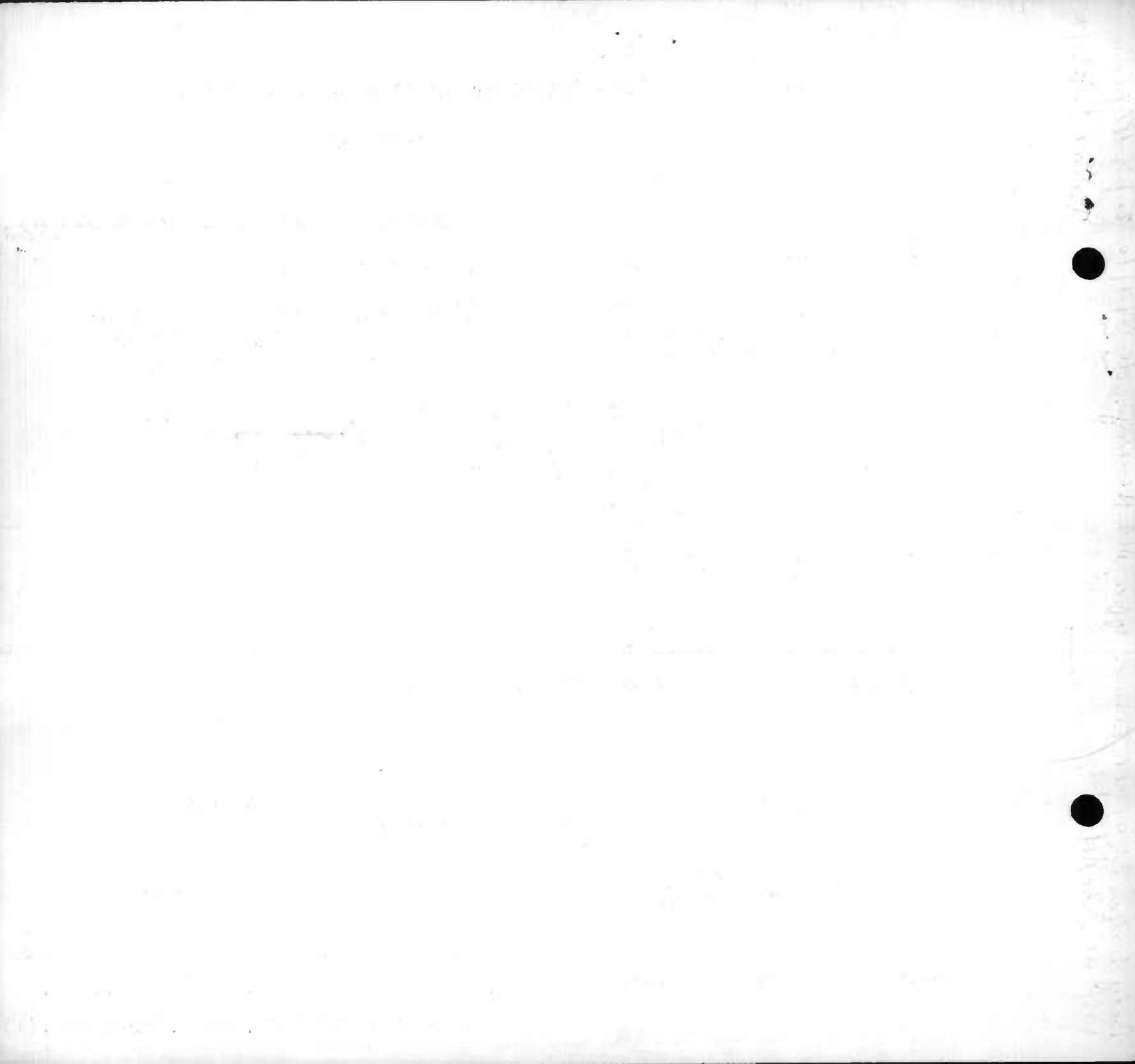
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 7867	REG. NO. 70 7867
BIRTH NO. K-215		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) IGNATIE I. KUZOVENKOFF		2. DATE AND HOUR OF DEATH 8. 7. 70 1. 40 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 301			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL 35		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 229 MASON COURT			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 18 1888	9. AGE (in years last birthday) 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHEMICAL LAB.		10B. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT		11. BIRTHPLACE (State or foreign country) SVERDLOVSK, RUSSIA	
13. FATHER'S NAME ILARION KUZOVENKOFF		14. MOTHER'S MAIDEN NAME UNK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 049-07-8033		17. INFORMANT ADDRESS FRANK RACHUCK 2205 E PRATT ST	
18. CAUSE OF DEATH 5-19-70 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Respiratory Failure (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Obstructive Lung Disease, Polycythemia Electrolyte Imbalance Dehydration, malnourishment.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 Hours Not Known Not Known Not Known
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE OLD INJURY OCCURRED (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW OLD INJURY OCCURRED	
22. I certify that (I) (this hospital) attended the deceased from 8. 6. 70 19 8. 7. 70 to 8. 7. 70 and that (I) (we) lost saw the deceased alive on 8. 7. 70 and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rustum. Irani M.D.		23B. DATE SIGNED 8. 7. 70		23C. PHYSICIAN'S NAME (Type) RUSTUM IRANI M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE AUG 10-70		24C. NAME OF CEMETERY OR CREMATORY ST ANDREW'S CEM.	
24D. LOCATION (City, town, or county) (State) GERMAN HILL RD BALTO MD		25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS THE DIPPEL BROS INC 1800 E LOMBARD ST			



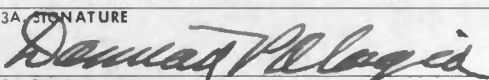
Body Released by Med. Exam. Office, MR. Henry, Jr. 8/14/70 as per telephone call at 9:20 AM. APPROVAL
FUNERAL DIRECTOR: IMPORTANT
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7868	
BIRTH NO. 70 7868				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BEASMAN VIOLA (VIOLA BEASMAN)		2. DATE AND HOUR OF DEATH 8/4/70 at 7:35AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 44 UNION MEMORIAL HOSPITAL.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1201			
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL.		C. CITY OR TOWN BALTIMORE.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3908, N. CHARLES STREET, BALT. MD.					
5. SEX Female	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/25/94	9. AGE (In years last birthday) 76 yrs.	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) WINCHESTER, VIRGINIA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John A. Ritter ADAM RITTER		14. MOTHER'S MAIDEN NAME Margaret Murray MARGARET MURRAY.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-44-3887		17. INFORMANT See Sec. No. 220-44-3887	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death) 410.9 + I288.2 Myocardial infarction		19. CAUSE OF DEATH See 410.9 + I288.2 Myocardial infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A)					
19A. DATE OF OPERATION 7/3/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TRACT. U.P.L.		20A. AUTOPSY? (Yes or No) Yes.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/1/70 19 to 8/4/70 19 that (I) (we) last saw the deceased alive on 7-30 AM 19 8/4/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mahmooda J. Lassie		23B. DATE SIGNED 8/4/70		23C. PHYSICIAN'S NAME (Type) Dr. Lassie	
23D. ADDRESS Union Memorial Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/70		24C. NAME OF CEMETERY or CREMATORY Springfield Cemetery	
24D. LOCATION Sykesville, Carroll Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR STEWART & MOWEN CO.	
25D. ADDRESS 108 W. North Ave. (1)					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7869
C-100 BIRTH NO. 1. NAME OF DECEASED (Type or Print) Sister Mary Ellen Coffey		2. DATE AND HOUR OF DEATH August 9, 1970 9:55 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 94 Villa Saint Michael		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY City C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4000 Forest Hill Road 21207		
5. SEX F.	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1888	9. AGE (In years last birthday) 82 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse - retired		10B. KIND OF BUSINESS OR INDUSTRY Sister of Charity		11. BIRTHPLACE (State or foreign country) Danbury, Connecticut
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James F. Coffey		
14. MOTHER'S MAIDEN NAME Anna I. Duffy		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 219-54-0260-11		17. INFORMANT Sister Andrea ADDRESS same address		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiovascular Collapse 4 days ANTECEDENT CAUSES Arteriosclerosis 18 years DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) None		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from April, 1952 19 to August, 1970 19 that (I) (we) last saw the deceased alive on August 6, 1970 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE 		23B. DATE SIGNED August 9, 1970		23C. PHYSICIAN'S NAME (Type) Damian P. Alagia, M.D.
23D. ADDRESS 3376 Frederick Ave. Bldg 29 Hk		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 8/11/70		24C. NAME OF CEMETERY or CREMATORY Villa St. Michael on grounds of Seton Institute,		24D. LOCATION 6400 Wabash Av., City.
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. North Av. Cit

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 7870		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 7870	
1. NAME OF DECEASED (Type or Print) <u>GREEN, Carrie</u>			2. DATE AND HOUR OF DEATH <u>9/6/70</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Harbor View H.C.</u>			A. STATE <u>MD.</u> B. COUNTY <u>HARCO.</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Belts General Hosp (D.O.A.)</u>			C. CITY OR TOWN <u>Annapolis</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <u>F</u> 6. RACE <u>XX</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>3-17-10</u>		9. AGE (In years last birthday) <u>60</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Arthur Green</u>			14. MOTHER'S MAIDEN NAME <u>Smith Louise</u>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary L. White Anna M.</u>
18. <u>41241</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Sepsis</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>II</u>			(B) <u>Ante-natal Cardiac Vascular Disease</u> YES (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>May 70</u> 19 <u>69</u> to <u>August 6</u> 19 <u>70</u> that (2) (we) last saw the deceased alive on <u>August 6</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did not) view the body after death.					
23A. SIGNATURE <u>A. C. A. Levi Zators, M.D.</u>			23B. DATE SIGNED <u>8/6/70</u>		23C. PHYSICIAN'S NAME (Type) <u>A. C. A. LEVI ZATORS, M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>8-11-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Broadneck</u>
24D. LOCATION (City, town, or county) (State) <u>St. Margarets MD</u>			25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. Sabin, M.D.</u>			25C. FUNERAL DIRECTOR <u>William Reese # Anna M.</u>		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

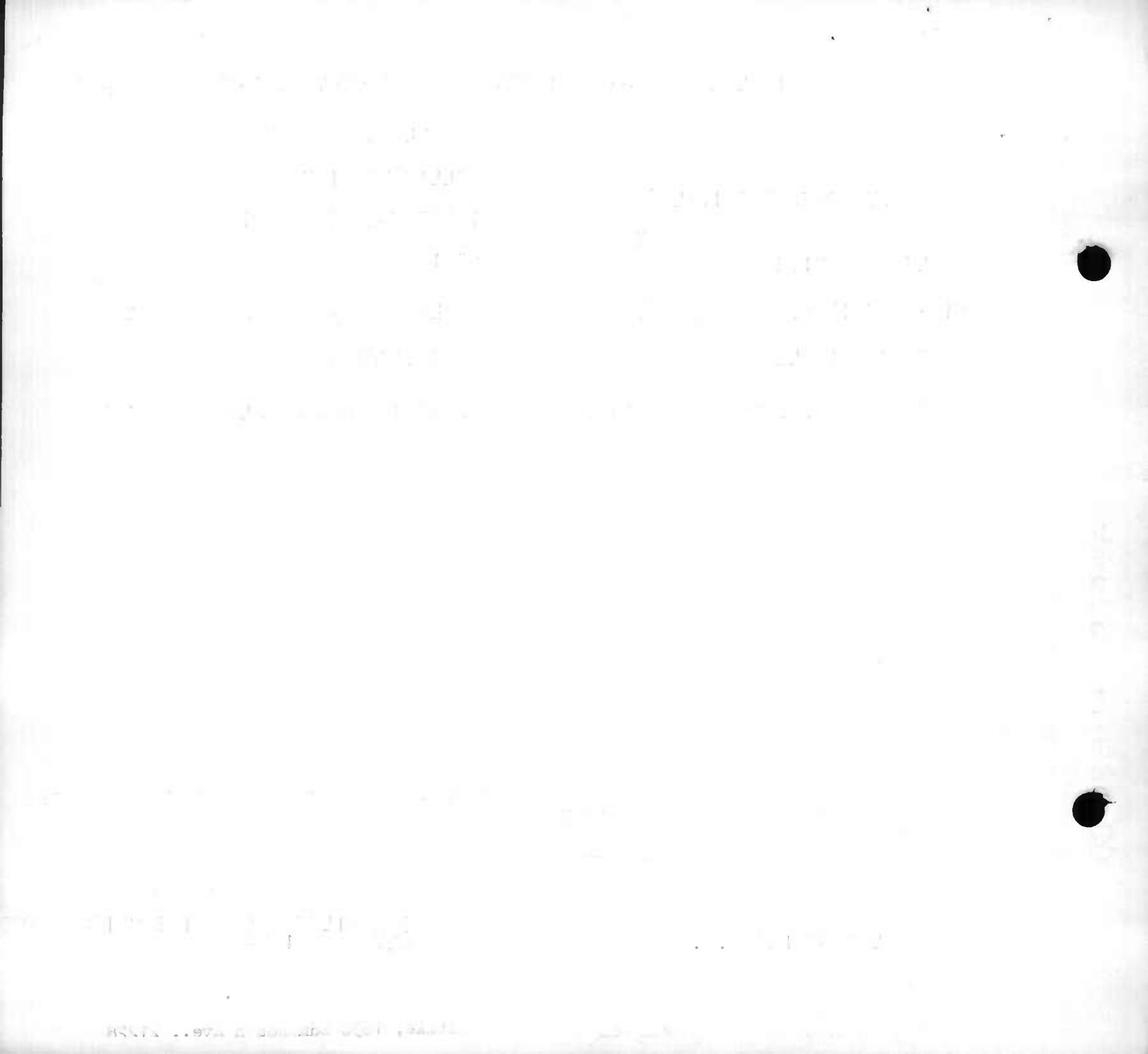
BALTIMORE CITY HEALTH DEPARTMENT		X	
REG. NO. <u>70 7871</u>		REG. NO. <u>70 7871</u>	
BIRTH NO. <u>S-300 70 7871</u>		BIRTH NO. <u>S-300 70 7871</u>	
1. NAME OF DECEASED (Type or Print) <u>SWIDWA, HELEN J.</u>		2. DATE AND HOUR OF DEATH <u>8/6/70</u> <u>11</u> <u>P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>BALTIMORE CITY HOSPITAL</u> <u>14940 Eastern Avenue</u> <u>Baltimore, Maryland 21222</u>		A. STATE <u>Maryland</u> 8. COUNTY <u>Baltimore</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>White</u>		E. STREET AND NUMBER <u>80 Yorkway 21222</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <u>75</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		8. DATE OF BIRTH <u>3/19/95</u>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>NOWACKI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>WACLAW</u>	
16. SOCIAL SECURITY NO. <u>215 16 6002</u>		17. INFORMANT <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u> BCH: Records	
18. <u>4/10/91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Asystole - pump failure</u> (B) <u>Acute Anterior myocardial infarction</u> (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hours</u> <u>16 hours</u>			
MEDICAL CERTIFICATION			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPST? (Yes or No) <u>Limited</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/6/70 10 AM</u> to <u>8/6 11 PM</u> 19 <u>70</u> and that (I) (we) last saw the deceased alive on <u>8/6</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Eloise Harman</u>		23B. DATE SIGNED <u>8/6/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Eloise Harman</u>		23D. ADDRESS <u>Baltimore City Hospitals 4940 Eastern Ave.</u> <u>2000 McElderry St Baltimore, Maryland 21205</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/11/70</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>ST. STANISLAUS</u>		24D. LOCATION (City, town, or county) (State) <u>DUNDALK MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>	
25C. FUNERAL DIRECTOR <u>JOHN M. WEBER, INC.</u>		25D. ADDRESS <u>401 S. LAMAR</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

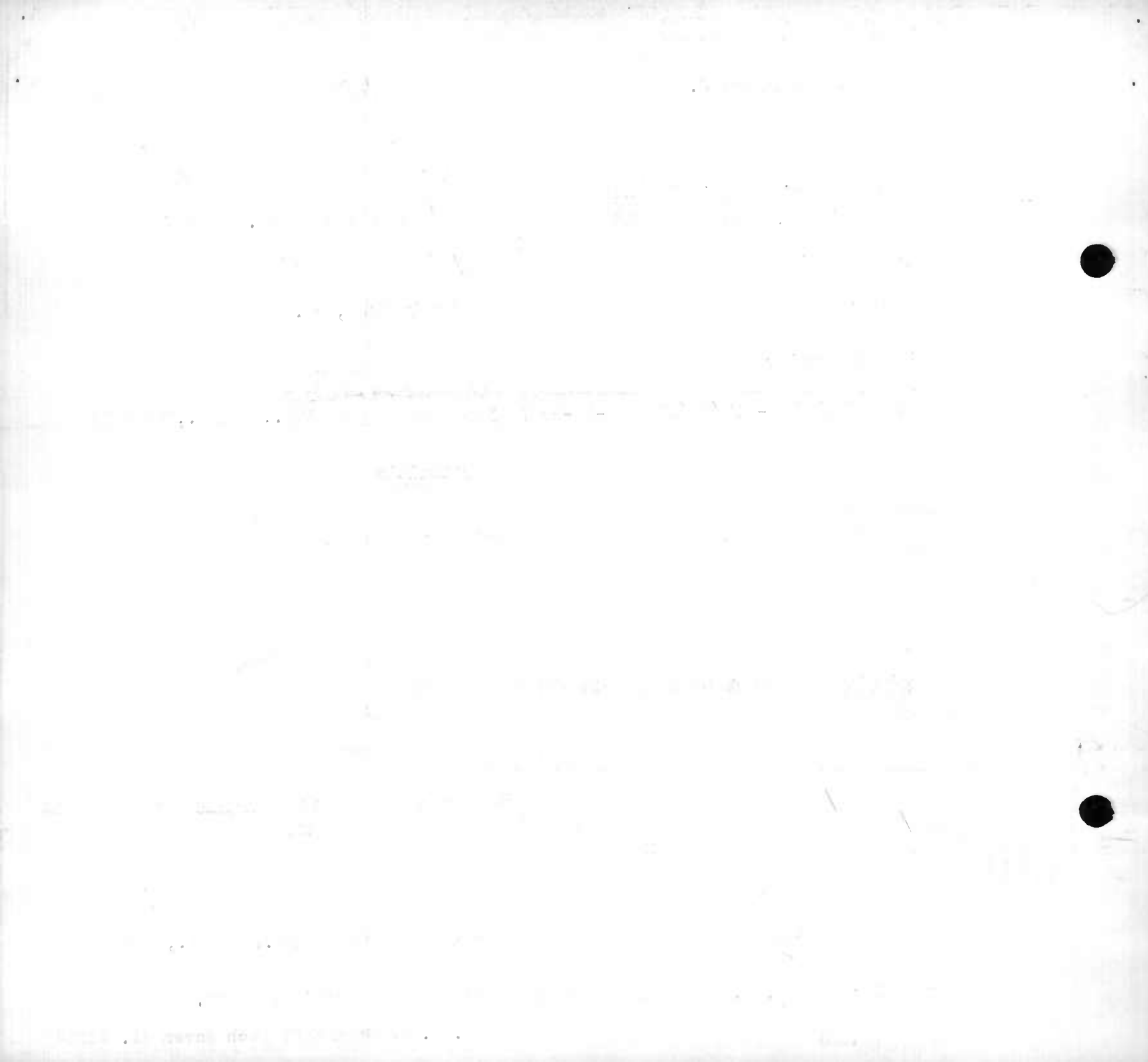
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 70 7872	
BIRTH NO. H-524		70 7872		CERTIFICATE OF DEATH			
1. NAME OF DECEASED <small>(Type or Print)</small> <div style="text-align: center; font-size: 1.2em;">HINKLEMAN, HOWARD RICHARD</div>				2. DATE AND HOUR OF DEATH <div style="text-align: center; font-size: 1.2em;">AUGUST 6, 1970 6: 20 P.M.</div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> FULL NAME OF HOSPITAL OR INSTITUTION <div style="font-size: 1.5em;">40 ST AGNES HOSPITAL</div> </div> <div style="width: 50%;"> <small>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</small> </div> </div>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> A. STATE <div style="font-size: 1.2em;">MARYLAND</div> </div> <div style="width: 50%;"> B. COUNTY <div style="font-size: 1.2em;">HOWARD</div> </div> </div>			
5. SEX <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> MALE </div> <div style="width: 50%;"> WHITE </div> </div>				6. RACE <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> WIDOWED </div> <div style="width: 50%;"> DIVORCED </div> </div>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH <div style="font-size: 1.2em;">07 16 23</div>			
9. AGE (In years last birthday) <div style="font-size: 1.2em;">47</div>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="font-size: 1.2em;">VICE PRESIDENT</div>			
11. BIRTHPLACE (State or foreign country) <div style="font-size: 1.2em;">MARYLAND</div>				12. CITIZEN OF WHAT COUNTRY? <div style="font-size: 1.2em;">U S A</div>			
13. FATHER'S NAME <div style="font-size: 1.2em;">GEORGE HINKLEMAN</div>				14. MOTHER'S MAIDEN NAME <div style="font-size: 1.2em;">ROSE GAUGHRAN</div>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> YES </div> <div style="width: 50%;"> W.W. 2 </div> </div>				16. SOCIAL SECURITY NO. <div style="font-size: 1.2em;">214 12 0893</div>			
17. INFORMANT <div style="font-size: 1.2em;">ST AGNES RECORDS BALTO</div>				ADDRESS <div style="font-size: 1.2em;">MD 21229</div>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)</small> <div style="font-size: 1.5em;">15-7-9 I</div>				CAUSE OF DEATH <div style="font-size: 1.2em;">(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pancreatic Carcinoma</div>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: 			
(C) DUE TO, OR AS A CONSEQUENCE OF: 				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <div style="font-size: 1.2em;">6 mos.</div>			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 		20A. AUTOPSY? (Yes or No) <div style="font-size: 1.2em;">NO</div>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <small>(Initally medical examiner)</small>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <small>(If in Baltimore City, give exact location)</small>			
21D. TIME OF INJURY (APPROX.) <small>(Month) (Day) (Year) (Hour)</small>		21E. INJURY OCCURRED <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> While At Work <input type="checkbox"/> </div> <div style="width: 50%;"> Not While At Work <input type="checkbox"/> </div> </div>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from AUGUST 5 19 70 to AUGUST 6 19 70 that (I) (we) last saw the deceased alive on AUGUST 6 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <div style="font-size: 1.5em;">Ralph Updike M.D.</div>				23B. DATE SIGNED <div style="font-size: 1.2em;">08 06 70</div>		23C. PHYSICIAN'S NAME (Type) <div style="font-size: 1.2em;">RALPH UPDIKE M.D.</div>	
23D. ADDRESS <div style="font-size: 1.2em;">#304 WILKENS AND PINE HEIGHTS AVE BALTO MD 21229</div>				24A. BURIAL CREMATION, REMOVAL (Specify) <div style="font-size: 1.2em;">Burial</div>			
24B. DATE <div style="font-size: 1.2em;">8/10/70</div>		24C. NAME of CEMETERY or CREMATORY <div style="font-size: 1.2em;">Crestlawn Cemetery</div>		24D. LOCATION (City, town, or county) (State) <div style="font-size: 1.2em;">Baltimore, Md.</div>		25A. DATE REC'D BY HEALTH DEPT. <div style="font-size: 1.2em;">AUG 10 1970</div>	
25B. NAME OF REGISTRAR <div style="font-size: 1.2em;">Robert E. Jaber, M.D.</div>		25C. FUNERAL DIRECTOR <div style="font-size: 1.2em;">Witzke, 1630 Edmondson Ave., 21228</div>					



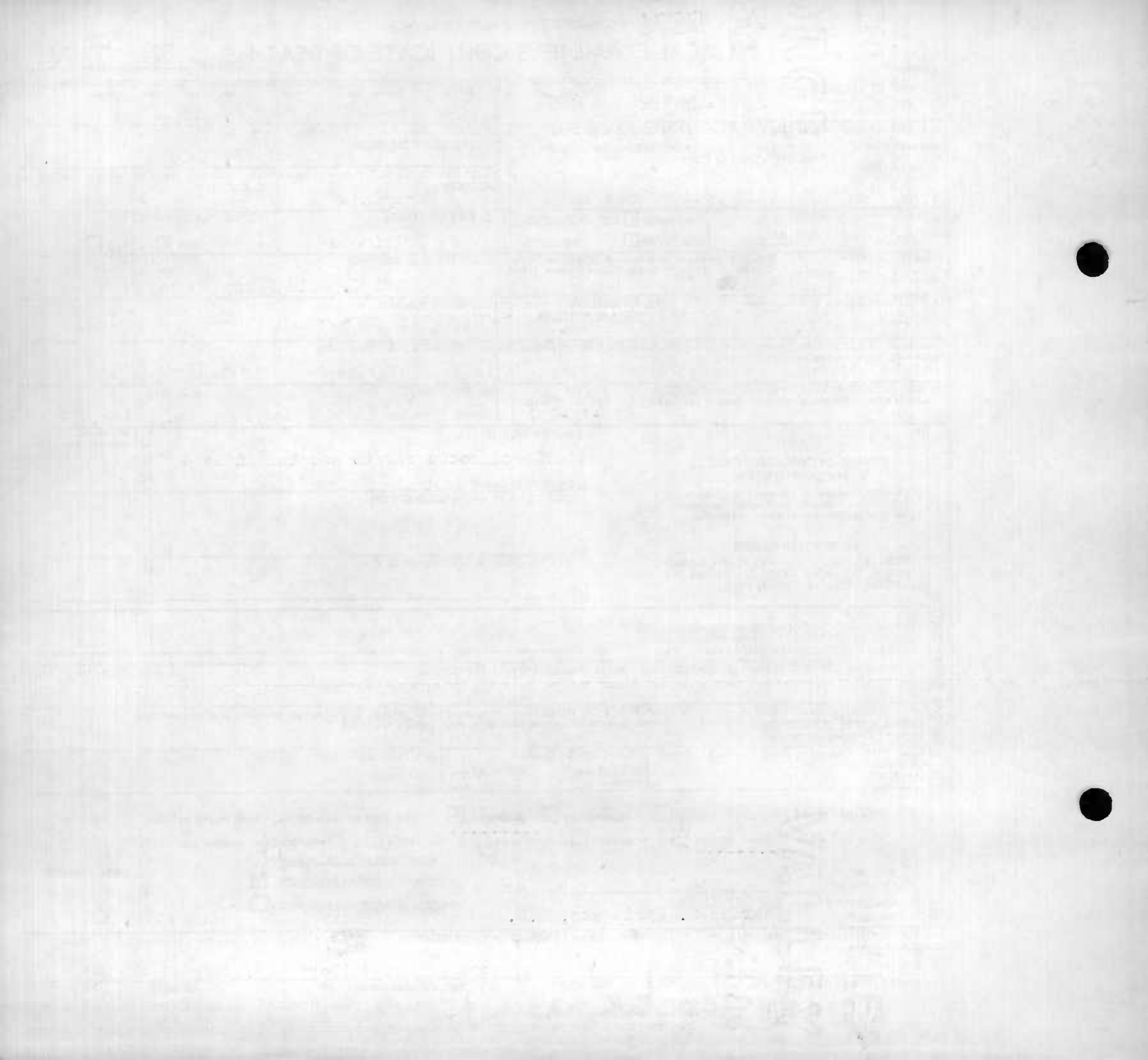
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-626 70 7873		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7873	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BRAZIER, George J.		2. DATE AND HOUR OF DEATH 8/5/70 9:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 902		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 3900 Loch Raven Blvd. 21218	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/7/95	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Downingtown, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Michael Brazier		14. MOTHER'S MAIDEN NAME Mary(MN Known)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10/4/17 - 12/11/17		16. SOCIAL SECURITY NO. 166-38-3067		17. INFORMANT VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218	
18. 3311 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Peritonitis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Perforated gastric ulcer		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Peritonitis (B) Perforated gastric ulcer DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 7/31/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated gastric ulcer		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from July 31st 19 70 to August 5th 19 70 that (A) (we) last saw the deceased alive on August 5th 19 70 and that (A) (our) opinion death occurred on the date and hour and from the causes stated above. (B) (We) (did) (not) view the body after death.					
23A. SIGNATURE <i>Spencer</i>		23B. DATE SIGNED 8/6/70		23C. PHYSICIAN'S NAME (Type) <i>Spencer</i>	
23D. ADDRESS 3900 Loch Raven Blvd., Balto., Md 21218		24A. BURIAL CREMATION, REMOVAL (Specify) Cremation			
24B. DATE Aug. 7, 1970		24C. NAME OF CEMETERY OR CREMATORY Charles Evans Crematory		24D. LOCATION (City, town, or county) (State) Reading, Penna.	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Wm. E. Johnson	
25D. ADDRESS 8521 Loch Raven Bl. 21204		VS 150-REV. 7/17/68			



70 7874 BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 7874	
BIRTH NO. S-315					
1. NAME OF DECEASED (Type or Print) JOHN STEVENS Stephens			2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 6, 1970 M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3025 Cold Spring Lane			3. DATE PRONOUNCED DEAD Month Day Year Hour August 6, 1970 6:30 A. M.		
6. SEX Male			5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1513		
7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH July 7, 1893		10. AGE (In years lost birthday) 76		E. STREET AND NUMBER 3003 W. Cold Spring Lane	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Stephens	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) night Watchman		14B. KIND OF BUSINESS OR INDUSTRY Watchman Wilbert Vault		15. MOTHER'S MAIDEN NAME Beula Stephens (Latham)	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 226-10-2614		18. INFORMANT ADDRESS Dora Bosley 3250 Southern Ave. Balto. 21214	
19. 412.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED August 6, 1970 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) EXH Burial		24B. DATE Aug. 10/70		24C. NAME OF CEMETERY or CREMATORY Lake View Cemetery	
24D. LOCATION (City, town, or county) (State) Liberty Rd. Carroll Co. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970			
25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR ADDRESS Loring Byers Funeral Directors P.A. 8728 Liberty Road Randallstown, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

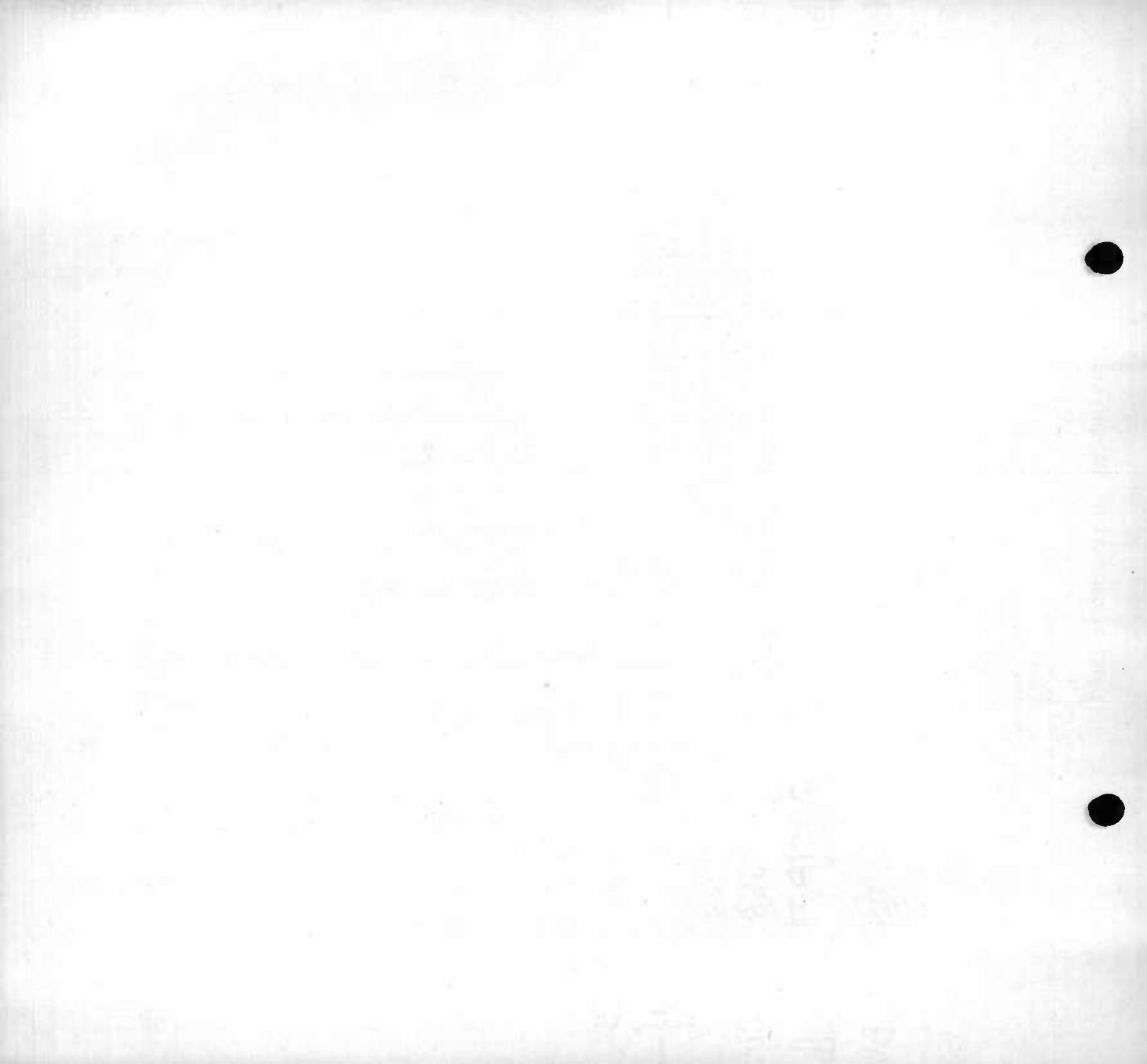
BALTIMORE CITY HEALTH DEPARTMENT											
REG. NO. 70 7875											
BIRTH NO. 1-500 70 7875											
1. NAME OF DECEASED (Type or Print) Charles E. Lam						2. DATE AND HOUR OF DEATH 8/7/70 5:30 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNION MEMORIAL Hospital						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1903					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL Hospital						C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
						E. STREET AND NUMBER 1704 Ramsey Street					
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/20/02		9. AGE (in years last birthday) 68		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTENDANT				10B. KIND OF BUSINESS OR INDUSTRY State Road, Md				11. BIRTHPLACE (State or foreign country) MARYLAND VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME MONROE Lam						14. MOTHER'S MAIDEN NAME NOT KNOWN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes #C 2				16. SOCIAL SECURITY NO. 212 18 9992		17. INFORMANT Wife - GENEVA LAM				ADDRESS SAME	
18. 441.21 CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SHOCK								(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last hypovolemia - anuria								(B) DUE TO, OR AS A CONSEQUENCE OF:			
								(C) Ruptured abdominal aortic aneurism			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION 8/6/70				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED fair to good				20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/6 19 70 to 8/7 19 70 that (I) (we) last saw the deceased alive on 8/7 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE [Signature] M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 8/7/70		
23C. PHYSICIAN'S NAME (Type) Carlos E. Fossi M.D.						23D. ADDRESS UNION MEMORIAL Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8-10-70		24C. NAME OF CEMETERY or CREMATORY Salem Lutheran Ch. Cemetery				24D. LOCATION (City, town, or county) (State) Mt. Jackson, Virginia	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970				25B. NAME OF REGISTRAR Robert E. Taber, Jr.				25C. FUNERAL DIRECTOR Thomas J. Kenny Inc ADDRESS 1600 Hollins St Balto Md			



FUNERAL DIRECTOR: IMPORTANT

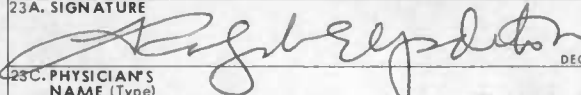
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

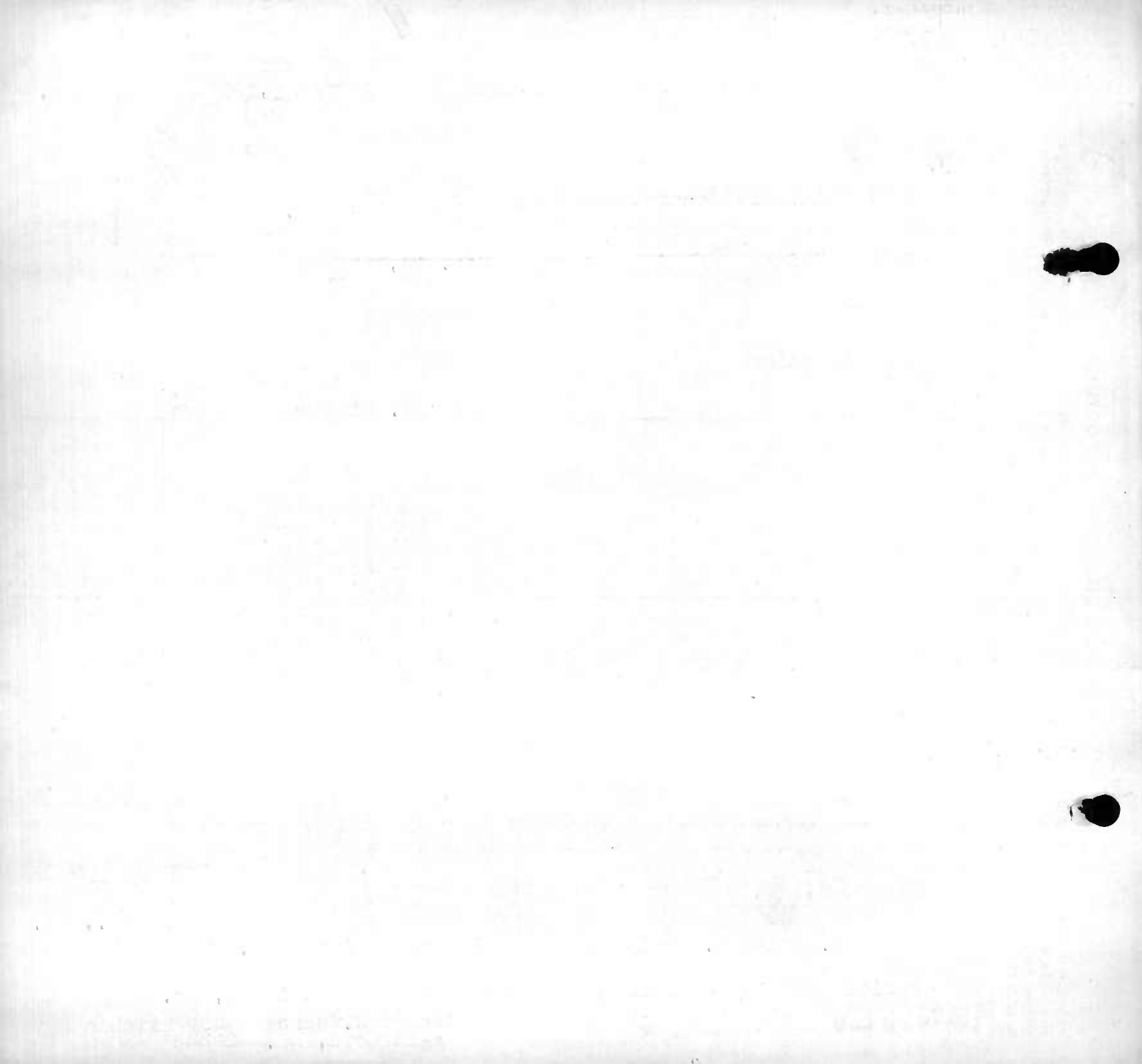
BALTIMORE CITY HEALTH DEPARTMENT				70 7876		REG. NO.	
B-626		70 7876		70 7876		70 7876	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
HARRY S. BRICKERD				AUG. 4, 1970		10 ⁵⁰ P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 005504 FREDERICK AVE.				A. STATE MD.		B. COUNTY 2854	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 5504 FREDERICK AVE.							
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 12, 1889	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOTTLE MOLD MAKER		10B. KIND OF BUSINESS OR INDUSTRY BUCK GLASS CO.		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE BRICKERD				14. MOTHER'S MAIDEN NAME FLORENCE HAUSMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Harry S. Brickerd-5504 Frederick Ave		ADDRESS	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Cerebrovascular thrombosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic CVD, generalized (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 8/7 to 8/14 19 70, that (1) (we) last saw the deceased alive on 8/4 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Herbert J. Levickas M.D.				23B. DATE SIGNED 8/6/70			
23C. PHYSICIAN'S NAME (Type) Herbert J. Levickas M.D.				23D. ADDRESS 5404 East Drive		(21227)	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-7-70		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cem.		24D. LOCATION (City, town, or county) (State) Woodlawn Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Foley-Corranough & Sons		ADDRESS 1000 E. St. N.W.	



FUNERAL DIRECTOR: IMPORTANT

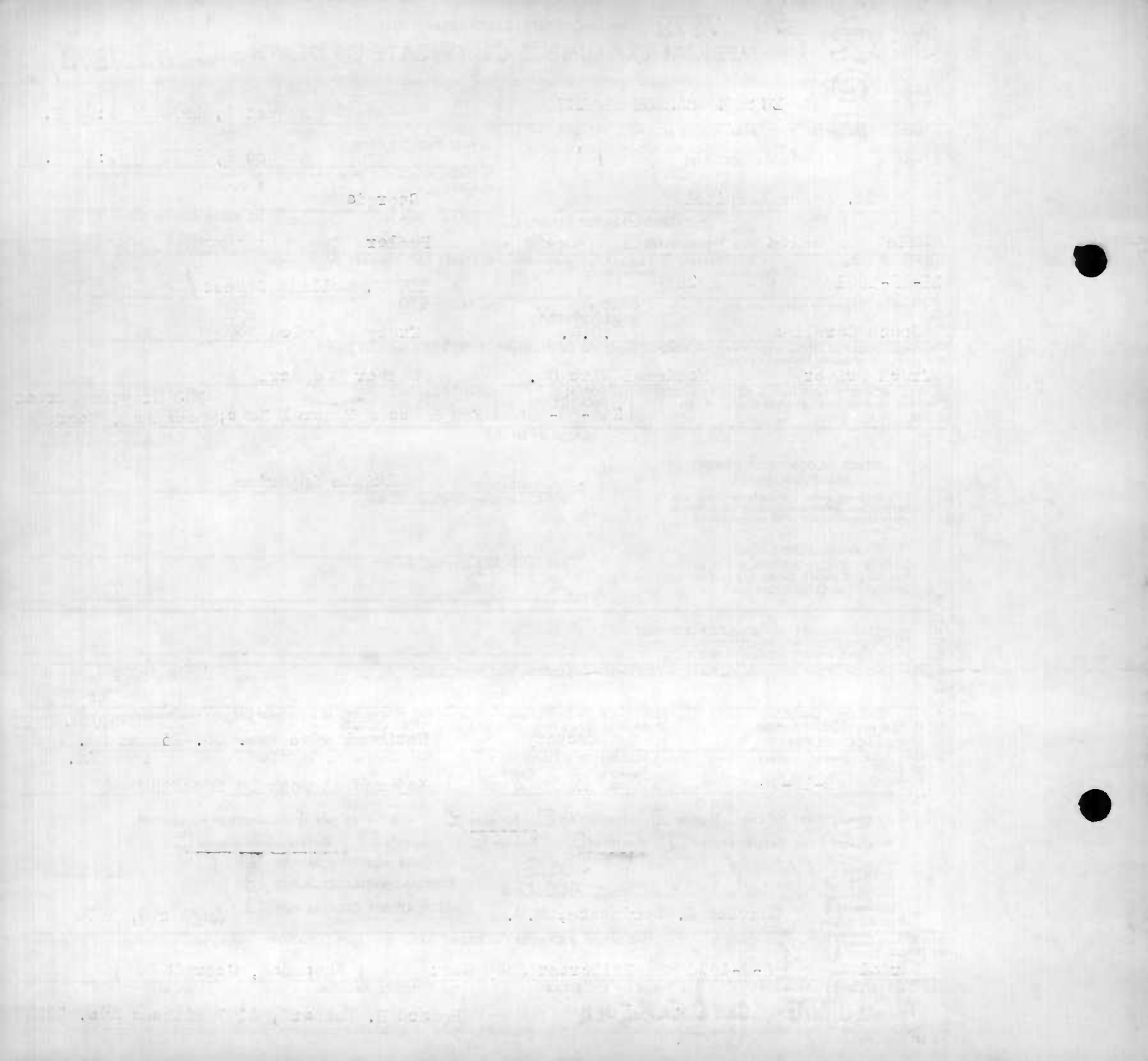
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7877	
T-455 70 7877		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
FRANCES ELIZABETH TILLMAN		August 5, 1970 4:45 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital		A. STATE		B. COUNTY	
		Maryland			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		3916 Sixth St.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 19, 1900	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Home		Maryland	
12. CITIZEN OF WHAT COUNTRY?		USA			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Kiessling			Mary		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				John A. Tillman	
				Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		Coronary Artery Disease		2 years	
		(B) DUE TO, OR AS A CONSEQUENCE OF:		4 years	
		(C) Congestive Heart Failure		2 years	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>69</u> to <u>Aug</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>13 July</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				8/7/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Ralph E. Udikey		Wilkins & Pine Hgts. Aves		Balto., Md.	
				21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/10/70		Loudon Park National	
				Baltimore, Md.	
25A. DATE RECD. BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 10 1970		Robert E. Taylor, Jr.		George J. Gonce	
				4001 Ritchie Hgy	
				Baltimore, Md. 21225	



1. NAME OF DECEASED (Type or Print) JOSEPH LEE ANGELO		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year August 6, 1970 Estimated <input type="checkbox"/> 6:20 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year August 6, 1970 6:20 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Pennsylvania B. COUNTY V-35	
9. DATE OF BIRTH May 1, 1951		10. AGE (In years lost birthday) 19	
11. BIRTHPLACE (State or foreign country) Roaring Springs, Pa		12. CITIZEN OF WHAT COUNTRY? U S A	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Const. Worker		14B. KIND OF BUSINESS OR INDUSTRY ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 184-42-5270	
18. INFORMANT Family, Perma.		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Construction	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? H. J. Williams Construction Co. Elkridge		22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 7 27 70 12:30	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Md. Howard County Developed heatstroke at work	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 6, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-10-7-	
24C. NAME of CEMETERY or CREMATORY Ave Maria		24D. LOCATION (City, town, or county) (State) Dudley Pa.	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Higinbotham Slack, Ellicott City, Md for Masgood Funeral Home, Saxton, Pa.			

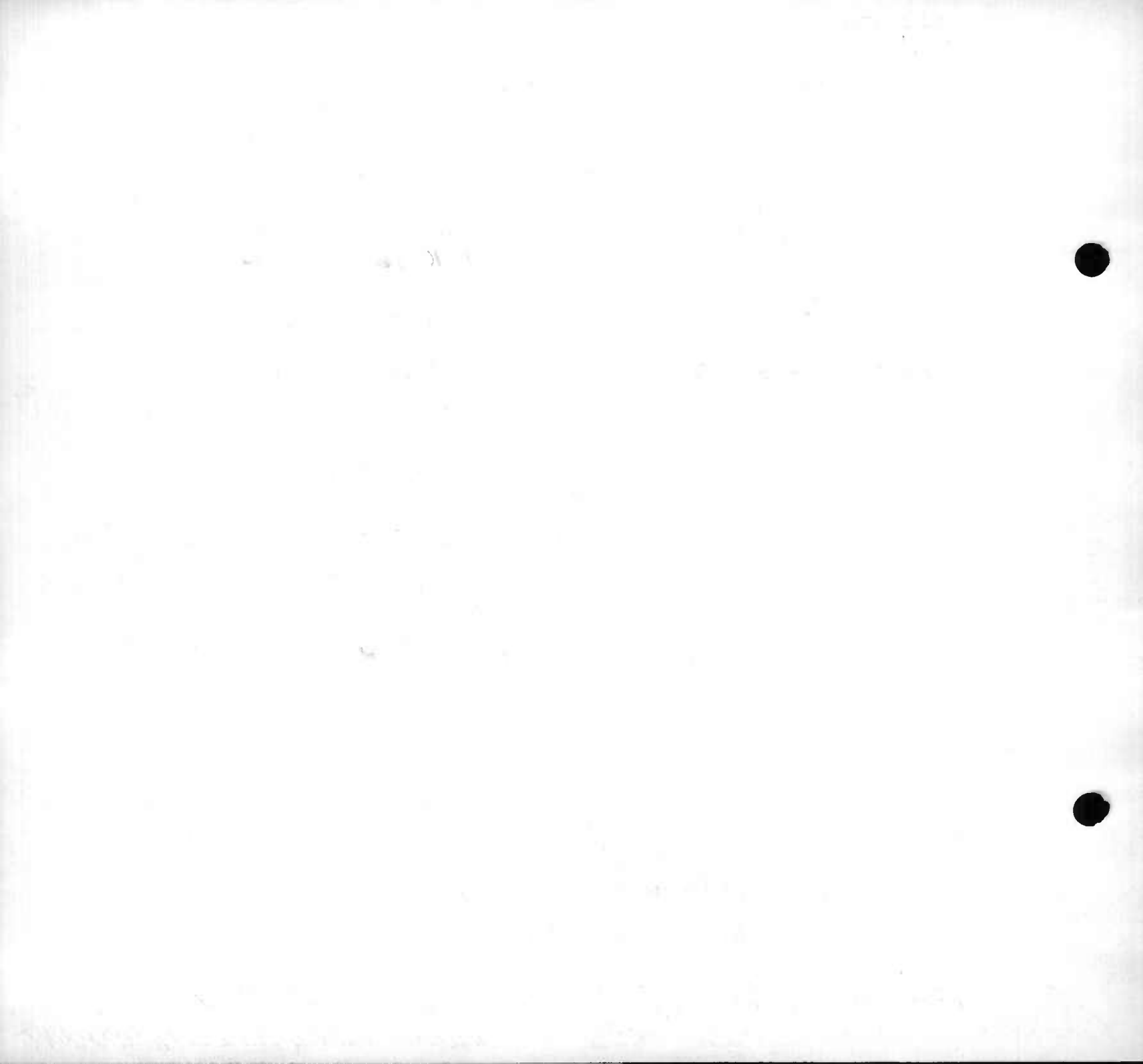
BIRTH NO.		REG. NO.	
B-450		70 7879	
BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
EUGENE CARSON BOLEN		Known <input checked="" type="checkbox"/> Month Day Year August 5, 1970	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year August 5, 1970	
40 St. Agnes Hospital		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Georgia V-09	
6. SEX	7. RACE	C. CITY OR TOWN	
Male	White	Pooler	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH	10. AGE (In years lost birthday)	E. STREET AND NUMBER	
11-15-1941	28	107 N. Collins Street	
11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	
South Carolina	U.S.A.	Tracy Bolen	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME	
Truck Driver	National Wire Co.	Esther Mae Bert	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	17. SOCIAL SECURITY NO.	18. INFORMANT ADDRESS	
No	248-64-4964	700 Dayton Street Fox & Weeks Funeral Home, Savannah, Georgia	
19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Multiple injuries DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No)	
		Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
	factory	Howard County National Wire Pro. Co. - Fisher Rd. & Penn Rd.	
22D. TIME OF INJURY (APPROX.)	22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?	
5-18-70		Injured at work by forklift	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE	EXAMINER'S NAME (Type)	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
Charles S. Springate	Charles S. Springate, M.D.	ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	August 6, 1970
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	8-8-1970	Hillcrest Abby West	Savannah, Georgia
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
AUG 10 1970	Robert E. Taylor, Jr.	Howard H. Hubbard	4107 Wilkens Ave. 21229



FUNERAL DIRECTOR: IMPORTANT

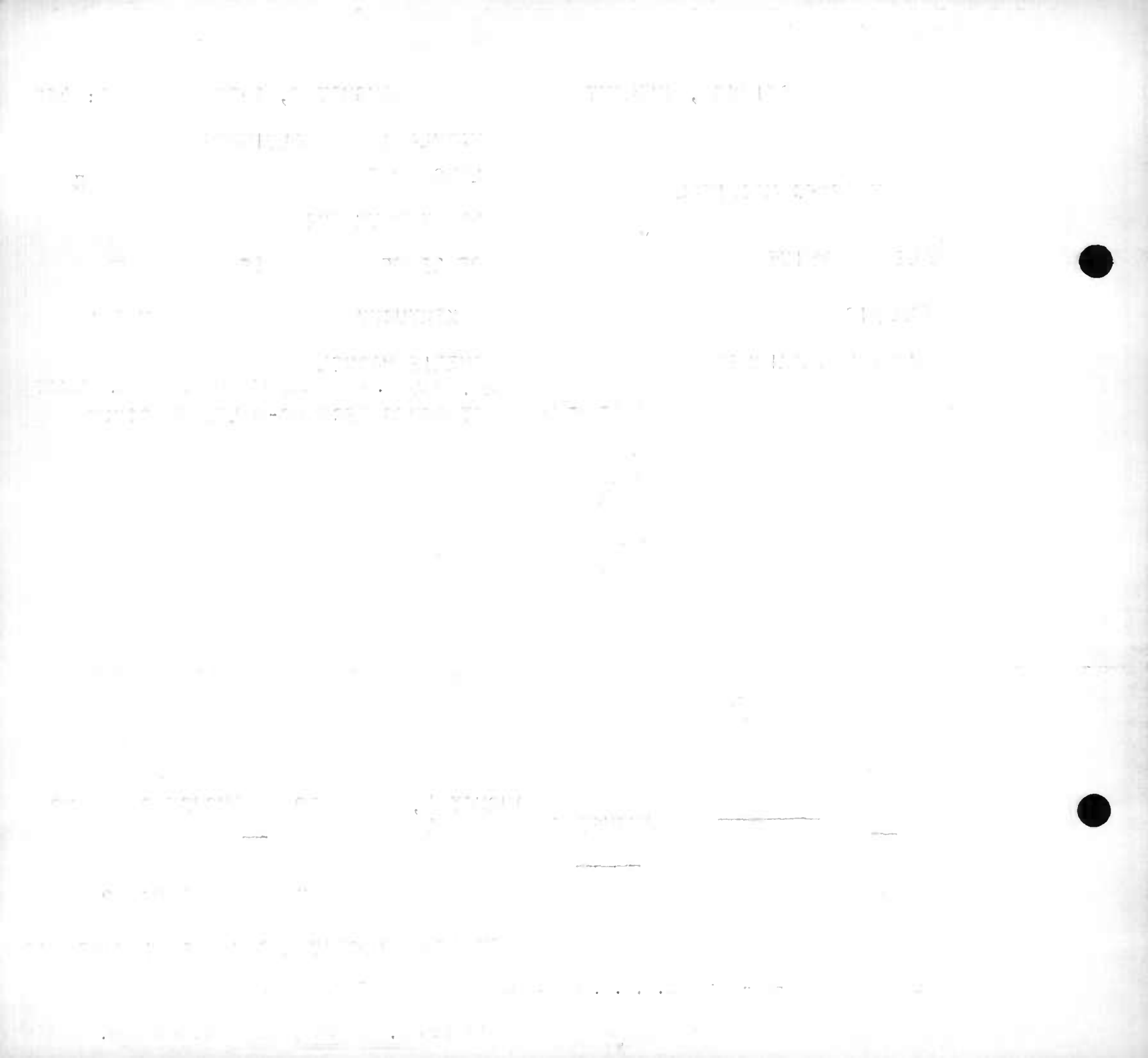
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-652 70 7880		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 7880	
1. NAME OF DECEASED (Type or Print) <u>Armstrong, Erle Lola</u>				2. DATE AND HOUR OF DEATH <u>Aug 6, 1970</u> <u>9²⁰ A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 University of Md. Hosp. Greene St. Baltimore, Md.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Baltimore, Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>1801</u> E. STREET AND NUMBER <u>933 W. Saratoga St.</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-16-96</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Gloucester Va</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Thomas West</u>				
14. MOTHER'S MAIDEN NAME <u>Martha Curtis</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>U</u>				
16. SOCIAL SECURITY NO.			17. INFORMANT <u>P. A. Mackowiak</u> ADDRESS <u>Univ. of Md. Hosp Baltimore Md.</u>				
18. <u>682.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Acute Resp. Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Aspiration Pneumonitis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Septicemia, obtundation due to suspected</u> <u>abdominal abscess</u> <u>Urinary infection</u> <u>gluteal abscess</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>i no.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>8-6-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7-11-70</u> 19 <u>70</u> to <u>Aug 6</u> 19 <u>70</u> that (I) <u>(We)</u> last saw the deceased alive on <u>Aug 6</u> 19 <u>70</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(I) (We)</u> (did) (did not) view the body after death.							
23A. SIGNATURE <u>Philip A. Mackowiak</u>				23B. DATE SIGNED <u>8-6-70</u>		23C. PHYSICIAN'S NAME (Type) <u>Philip A. Mackowiak</u> M.D.	
23D. ADDRESS <u>Univ. of Md. Hosp., Baltimore, Md.</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>8/10/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>974 Auburn Cem. Balto. Md</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taber, Jr.</u>		25C. FUNERAL DIRECTOR <u>Williams Funeral Home 3199 Schroeder St</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 70 7881	
S-560 70 7881				BIRTH NO.			
1. NAME OF DECEASED (Type or Print) SKINNER, EVERETT				2. DATE AND HOUR OF DEATH AUGUST 5, 1970 7: 45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 5300			
				C. CITY OR TOWN LANSDOWNE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 220 FOURTH AVE			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05 23 05	9. AGE (in years last birthday) 65	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) KENTUCKY		
12. CITIZEN OF WHAT COUNTRY? U S A			13. FATHER'S NAME JOSEPH B SKINNER				
14. MOTHER'S MAIDEN NAME SUZZIE MARVEL			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. 401-61-5999			17. INFORMANT Mrs. Mary M. Skinner, 220 Fourth Ave. 21227				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			19. CAUSE OF DEATH IMMEDIATE CAUSE Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF: 2nd & 3rd degree burn 90% DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 8-4-70			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>				
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 220 FOURTH AVE. 5300				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 8-4-70 3:30 PM			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR? CLEANING PAINT BRUSHES WITH GASOLINE WHEN IT IGNITED			22. I certify that (I) (this hospital) attended the deceased from AUGUST 4, 1970 to AUGUST 5, 1970 that (I) (we) last saw the deceased alive on AUGUST 5, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Pricha Boonswang M.D.			23B. DATE SIGNED 08 05 70			23C. PHYSICIAN'S NAME (Type) DR. PRICHA BOONSWANG	
23D. ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE			24A. BURIAL CREMATION, REMOVAL (Specify) Burial				
24B. DATE 8-10-1970			24C. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery				
24D. LOCATION (City, town, or county) (State) Clay, Kentucky			25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970				
25B. NAME OF REGISTRAR Robert E. Hubbard			25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 7882	
B-635 70 7882 BIRTH NO. 1. NAME OF DECEASED (Type or Print) BRITTNER, Daniel		2. DATE AND HOUR OF DEATH 8/5/70			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Asheville, N.C. 5. CITY OR TOWN D. INSIDE CITY LIMITS? Asheville YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 70 Kenilworth Road			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/11/96	9. AGE (In years last birthday) 74	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Press Feeder		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Daniel Brittner			
14. MOTHER'S MAIDEN NAME Margaret (MN Unknown)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 2/26/18 - 4/7/19			
16. SOCIAL SECURITY NO. 217-24-8558		17. INFORMANT V.A. Hospital Records ADDRESS 3900 Loch Raven Blvd., Balto., Md 21217			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 440.917-154.1 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE Cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF: (B) Cardiac irregularity DUE TO, OR AS A CONSEQUENCE OF: (C) ASVD					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Post op A-P Resection					
19A. DATE OF OPERATION 7-22-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Rectum		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 24th 19 70 to August 5th 19 70 that (I) (we) last saw the deceased alive on August 5th 19 70 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Juanangrand</i>				23B. DATE SIGNED 8/6/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS 3900 Loch Raven Blvd., Balto., Md	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-7-70		24C. NAME OF CEMETERY OR CREMATORY FOREST LAWN CEM	
24D. LOCATION (City, town, or county) (State) BUNCOMB, CO. NORTH CAROLINA		25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR HOWARD H. HUBBARD F.H.			

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THE HUBBARD F.H. ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 7883
BIRTH NO. B-420		1. NAME OF DECEASED (Type or Print) BOLEK, ELIZABETH A		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL		2. DATE AND HOUR OF DEATH AUGUST 4, 1970 1:35P^M		
5. SEX FEMALE		6. RACE WHITE		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 01/18/90		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Arundel Ice Cream Co.		
13. FATHER'S NAME HENRY NEUMEISTER		14. MOTHER'S MAIDEN NAME unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 212-30-6685		
17. INFORMANT ST. AGNES HOSPITAL RECORDS		ADDRESS		
18. CAUSE OF DEATH 450X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Hydrothorax hydroaeterns				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from AUGUST 4, 1970 to AUGUST 4, 1970 that (I) (we) last saw the deceased alive on AUGUST 4, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE G Patrick M.D.		23B. DATE SIGNED 08 04 70		23C. PHYSICIAN'S NAME (Type) G PATRICK M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/70		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.
				ADDRESS 3331 Brehms Lane

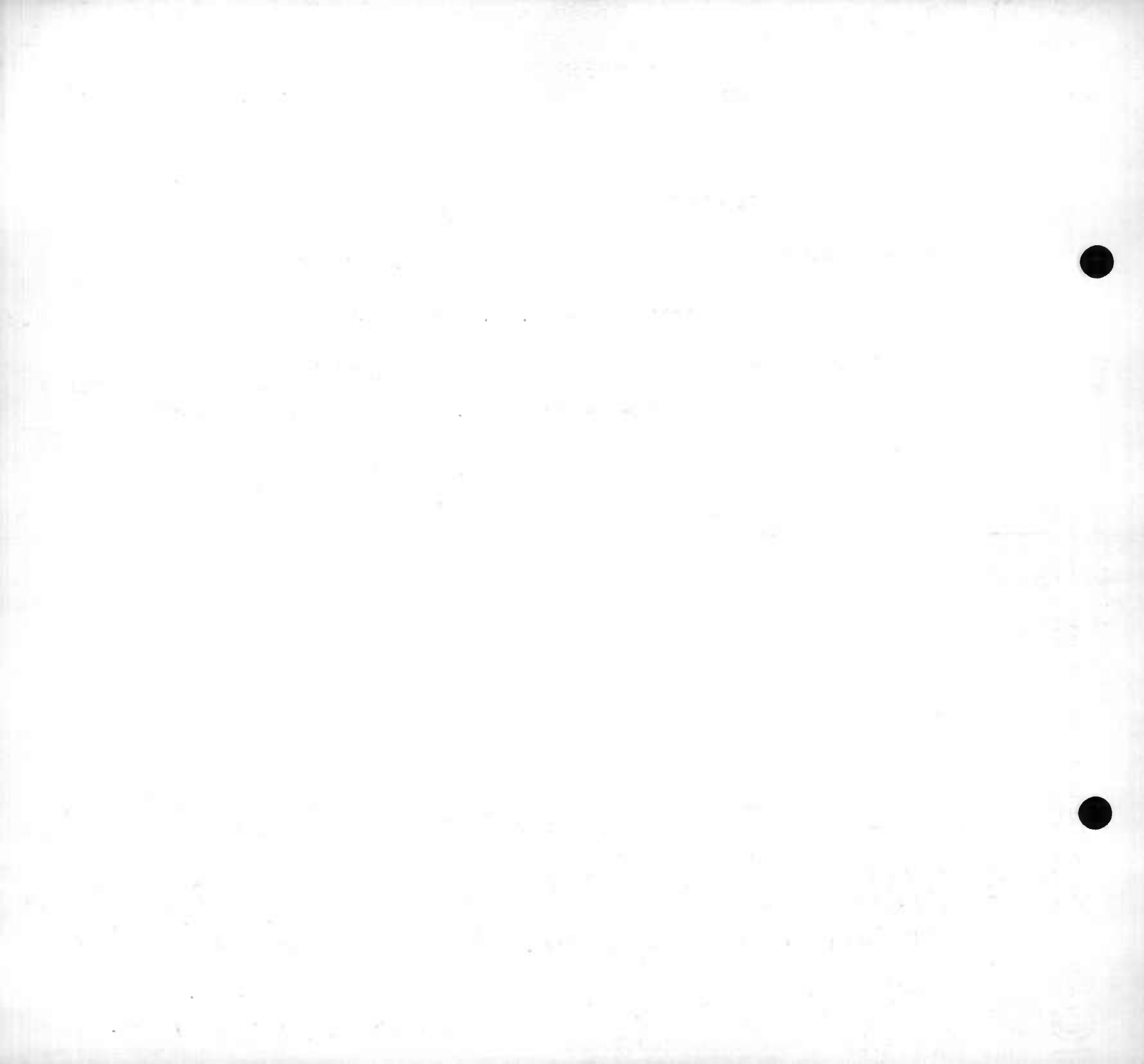
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1554 Elring St., Admitted

70 Jenkins 1/20/70

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-620 70 7884		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7884	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Donley Winfred Church</u>		2. DATE AND HOUR OF DEATH <u>August 3, 1970</u> <u>7:20 P.M.</u>	
3. PLACE (IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD) <u>37 Mercy Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>2634</u>		C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital</u>		E. STREET AND NUMBER <u>1148 Quantril Way</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1900</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Williams Constr. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>William Church</u>		14. MOTHER'S MAIDEN NAME <u>Delie McMillian</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>246-03-2799</u>		16. SOCIAL SECURITY NO. <u>246-03-2799</u>		17. INFORMANT <u>1018 Card Street</u> ADDRESS <u>21220</u> <u>Mr. Odell Woodie, son-in-law</u>	
18. <u>6201</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cancer of lung</u> DUE TO, OR AS A CONSEQUENCE OF: <u>w/ht metastases</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 27</u> 19 <u>70</u> to <u>August 3</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>August 3</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. Sheldon Eastland MD</u>		23B. DATE SIGNED <u>August 4, 1970</u>			
23C. PHYSICIAN'S NAME (Type) <u>J. SHELDON EASTLAND MD</u>		23D. ADDRESS <u>Med. Arts Bldg. Baltimore Md</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/6/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Crest Lawn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>	
				ADDRESS <u>3331 Brehms Lane</u>	



BIRTH NO.

70 7885

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7885

1. NAME OF DECEASED (Type or Print) Emaline Hettie E. Lang		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> Month 8 Day 4 Year 79 Hour 10:40 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 5003 Wright Avenue		3. DATE PRONOUNCED DEAD Month 8 Day 4 Year 70 Hour 10:40 a. M.	
6. SEX female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2634	
9. DATE OF BIRTH 8/29/02		10. AGE (In years last birthday) 67	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Daniel Rogers		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Mattie Bowling		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 212-05-2032		18. INFORMANT ADDRESS John F. Lang, husband, above	
19. #12.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Deputy Chief Medical Examiner ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/4/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/70	
24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Sabey, M.D.	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane	

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S-655 70 7886 BALTIMORE CITY HEALTH DEPARTMENT MEDICAL EXAMINER'S CERTIFICATE OF DEATH 70 7886

BIRTH NO. REG. NO.

1. NAME OF DECEASED (Type or Print) JOHN SKIRMEN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 6000 Morvia Park Drive (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour August 4, 1970 2:15 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 11/26/1898		10. AGE (In years lost birthday) 71	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Presser		14B. KIND OF BUSINESS OR INDUSTRY Daroff	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 214-05-3591	
18. INFORMANT Mrs. Zena Matranga Skirmen, wife, above		ADDRESS	
19. E 95010 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) OVERDOSE OF BARBITURATES ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Overdose of barbiturates (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 6000 Moravia Park Drive		22F. HOW DID INJURY OCCUR? Ingested overdose of Tuinal.	
22D. TIME OF INJURY (APPROX.) 8-4-70		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		DATE SIGNED 8/5/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/70	
24C. NAME OF CEMETERY or CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane			

VS 151-REV. 1/1/68

Paul Miller

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V-235

70 7887

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7887

1. NAME OF DECEASED (Type or Print) T. GLADYS VOGTMAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 001920 N. Chester Street		3. DATE PRONOUNCED DEAD Month Day Year Hour August 4, 1970 3:15 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 805		6. SEX Female 7. RACE White 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 10/21/1901 10. AGE (in years lost birthday) 68		11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME Walter H. Markley		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Carrie Otto		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 218-48-6703		18. INFORMANT ADDRESS Viola A. Sommer, sister, 3229 Elmley Av.	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/5/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/7/70	
24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane	

MEDICAL EXAMINATION CERTIFICATE

NAME OF PATIENT

DATE OF EXAMINATION

NAME OF PHYSICIAN

ADDRESS

CITY

STATE

COUNTY

ZIP CODE

PHYSICIAN'S SIGNATURE

DATE OF SIGNATURE

PHYSICIAN'S LICENSE NUMBER

PHYSICIAN'S EXPIRATION DATE

PHYSICIAN'S CATEGORY

PHYSICIAN'S SPECIALTY

PHYSICIAN'S BOARD

PHYSICIAN'S BOARD NUMBER

PHYSICIAN'S BOARD EXPIRATION DATE

PHYSICIAN'S BOARD CATEGORY

PHYSICIAN'S BOARD SPECIALTY

PHYSICIAN'S BOARD BOARD

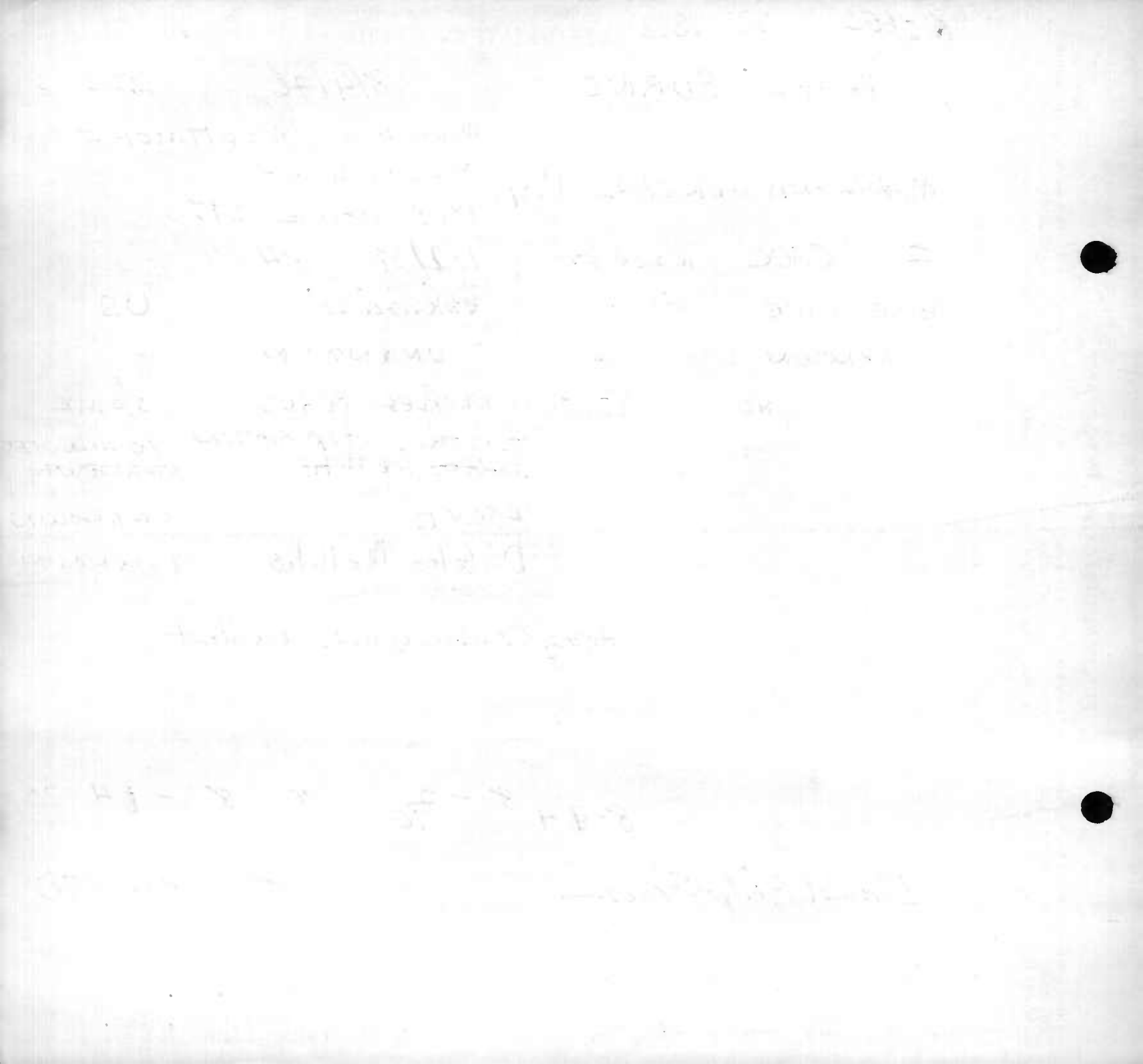
PHYSICIAN'S BOARD BOARD NUMBER

PHYSICIAN'S BOARD BOARD EXPIRATION DATE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-652		70 7888		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 7888	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				S. PEARL BURNS		8/4/70 2:22 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
MARYLAND GENERAL HOSP.				MARYLAND, BALTIMORE 909			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				1813 HOPE ST.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		
F	CAUC	MARRIED	1/2/86	84			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSE WIFE		at home		Baltimore, Md.		US	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
UNKNOWN Elmer Robinson				UNKNOWN Ida Evans			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		705-10-4074B UNKNOWN		CHARLES BURNS		SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
25019 I				Gastric Aspiration		10 MINUTES	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		UNKNOWN	
ANTECEDENT CAUSES				(B) DUE TO		UNKNOWN	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO		UNKNOWN	
				ASCVD			
				Diabetes Mellitus			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				History Cerebrovascular accident			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8-2 19 70 to 8-4 19 70, that (I) (we) last saw the deceased alive on 8-4 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
David Philip Green M.D.				8/4/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/7/70		Baltimore Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 10 1970		Robert E. Taylor, Jr.		Schimunek Funeral Home, Inc.		3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

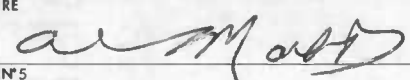
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

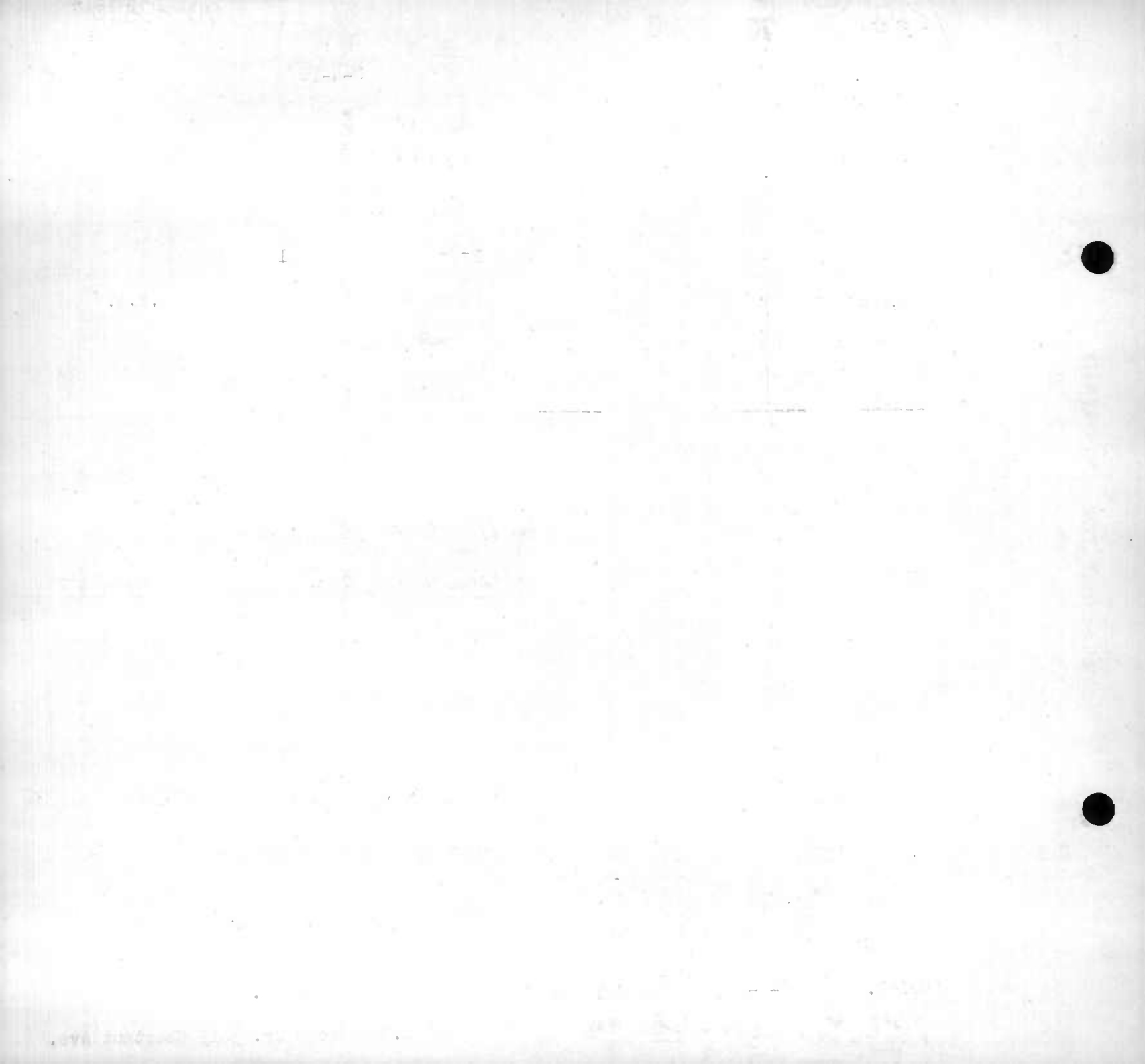
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7889	
F-600 BIRTH NO. 70 7889		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Dominic FIORE			2. DATE AND HOUR OF DEATH 8/5/70 12:20am		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Good Samaritan Hospital FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Good Samaritan Hospital 560I Loch Raven Blvd Baltimor Md. 21212			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY _____ C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1000 Forest St		
5. SEX M	6. RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/8/81	9. AGE (in years lost day) 89	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER marine			10B. KIND OF BUSINESS OR INDUSTRY HOTEL		11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME not known		
14. MOTHER'S MAIDEN NAME not known			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) not known		
16. SOCIAL SECURITY NO. 21-0736280			17. INFORMANT ADDRESS Mr. Ralph NORTON 4503 MARY AVE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) 600X I			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Haemorrhage from Bladder Prostatic hypertrophy (B) DUE TO, OR AS A CONSEQUENCE OF: Generalised arteriosclerosis Bilateral deep vein thrombosis (C) _____		
19. DATE OF OPERATION 0			20. AUTOPSY? (Yes or No) NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 402I Deepwood Rd Balt Md 21218		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (this hospital) attended the deceased from 7 - 20 1970 to 8 - 5 - 1970 , that (I) was last saw the deceased alive on 19 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.					
23A. SIGNATURE David J Tiller			23B. DATE SIGNED 8/5/70		
23C. PHYSICIAN'S NAME (Type) David J Tiller MB.BS.MRACP			23D. ADDRESS 402I Deepwood Rd Balt Md 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-8-70		24C. NAME OF CEMETERY or CREMATORIUM MOST HOLY REDEEMER BALTO., MD.	
24D. LOCATION (City, town, or county) (State) BALTO., MD.		25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR J. Walter Conklin		ADDRESS 5444 BELAIR Rd.			

7 Forrest St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-300 70 7890		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7890	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOSEPHINE KATO		2. DATE AND HOUR OF DEATH 8-4-70 7:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BOLTON HILL NURSING CENTER		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1306		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8-3-79		9. AGE (In years last birthday) 91		10. U.S. CITIZENSHIP (If Under 1 Yr. Months; Days; If Under 24 Hrs. Hours; Min.)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FENWICK. SIMMS		14. MOTHER'S MAIDEN NAME DUNLAPS, CORA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. -----		17. INFORMANT ADMISSION RECORD	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: central aneurysm (B) DUE TO, OR AS A CONSEQUENCE OF: arteriosclerosis (C) DUE TO, OR AS A CONSEQUENCE OF: arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8/3/70 years years	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 8		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/28 1967 to 8/7 1970, that (I) (we) last saw the deceased alive on 8/7 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED 8/5/70		23C. PHYSICIAN'S NAME (Type) ALLAN H. MALTBY MD	
23D. ADDRESS 2 E. Reed St. Balto. Md.		23E. DATE REC'D BY HEALTH DEPT. AUG 10 1970		23F. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial.		24B. DATE 8-8-70		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
24D. LOCATION Balto.		24E. FUNERAL DIRECTOR Paul E. Chenoweth Jr.		24F. ADDRESS 3615 Chestnut Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-653		70 7891		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7891	
BIRTH NO.				1. NAME OF DECEASED Richard Brandt (Type or Print) RICHARD BRANDT			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 6 Aug 70 - 13 ³⁰ P-M. M.			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND		B. COUNTY 301	
B/ BALTIMORE CITY HOSPITALS		4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		24 1619 E. Baltimore Street		21224			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 22 Nov 83	9. AGE (In years last birthday) 86	10. UNDER 1 Yr. Months Days	11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Construction Work		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME WILLIAM Brandt				14. MOTHER'S MAIDEN NAME IDA OSA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-34-2900A		17. INFORMANT 4940 Eastern Avenue Baltimore, Maryland 21224			
18. 412.41		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE Cardiac Arrest		DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) Atherosclerotic CVD with Aneurysm		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(C)					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Suprapubic Cystostomy		5 years	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 17 Oct 67 19 to 6 Aug 70 19 that (I) (we) last saw the deceased alive on 6 Aug 70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Edmund Beacham M.D.				23B. DATE SIGNED 6 Aug 70			
23C. PHYSICIAN'S NAME (Type) Edmund Beacham M.D.				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/70		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR John J. Duda		25D. ADDRESS 7922 Wise Ave. Dundalk, Md.	

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EB-185

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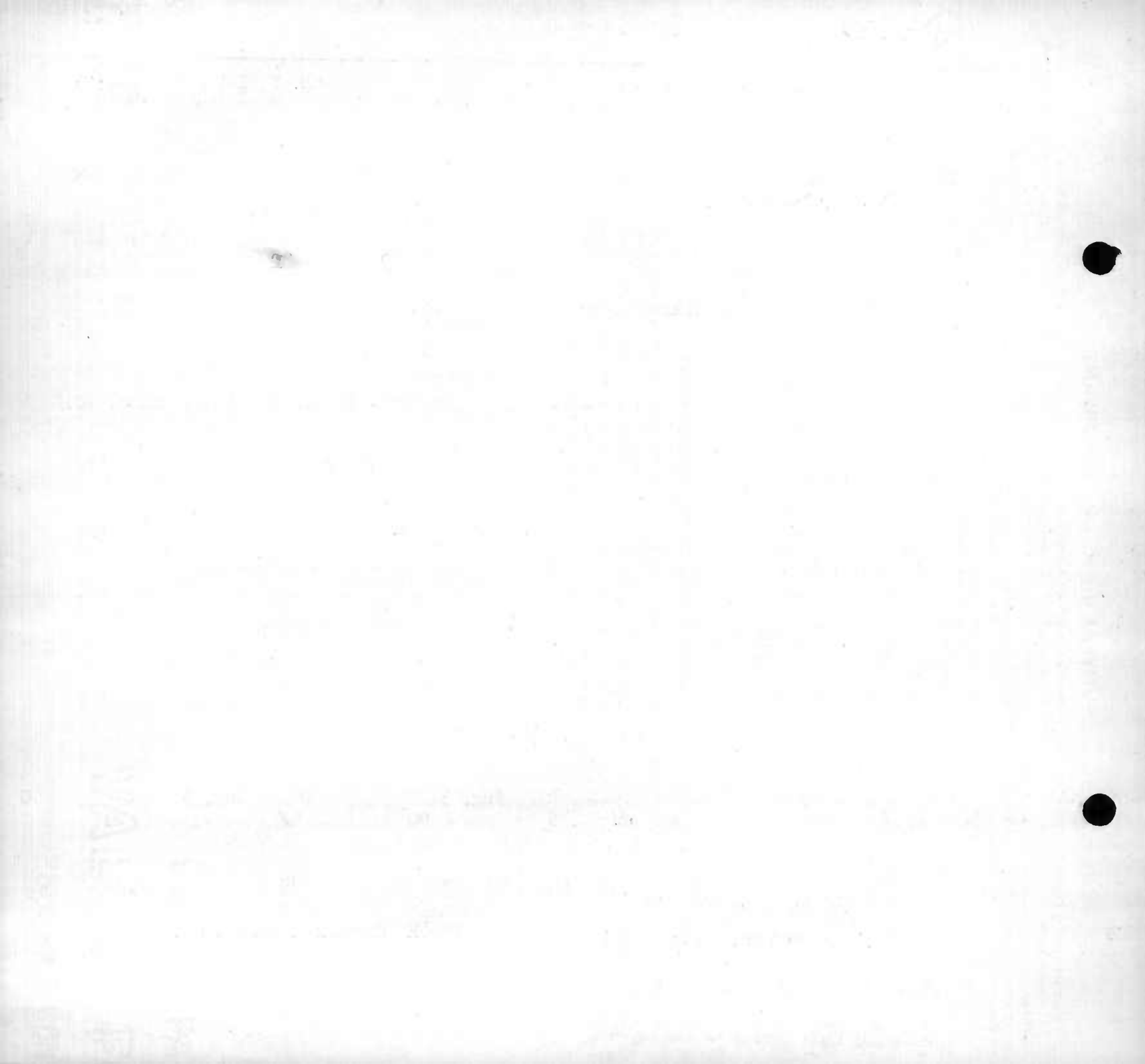
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-150		70 7892		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 7892	
BIRTH NO.									
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
Mae Adeline Devon					Aug. 5, 1970 12:53 A M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					A. STATE B. COUNTY				
US Public Health Service Hospital					Md. Balto. 5300				
3100 Wyman Parkway					C. CITY OR TOWN D. INSIDE CITY LIMITS?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
E. STREET AND NUMBER					4623 Ridgeway Ave.				
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birth)	
F		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9/29/89		80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired				Housekeeper		Pa.		USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
?					?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				150-26-9114		Records- US PHS Hospital, Balto, Md.			
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					Septic shock				
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
ANTECEDENT CAUSES					Hemorrhagic enteritis				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO, OR AS A CONSEQUENCE OF:				
					(C) DUE TO, OR AS A CONSEQUENCE OF:				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				yes		yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		White <input type="checkbox"/> Not White <input type="checkbox"/>							
		Work <input type="checkbox"/> At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from Aug. 3 1970 to Aug. 5 1970, that (I) (we) last saw the deceased alive on Aug. 5 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
Gary E. Feldman, M.D.					8/5/70				
23C. PHYSICIAN'S NAME (Typed)					23D. ADDRESS				
Gary E. Feldman, SA Surg (R)					US PHS Hospital, Balto, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		8/5/70		Moreland Memorial Cem.		Balto. Co. Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
AUG 10 1970		Robert E. Feldman, M.D.		Lassahn Funeral Home		2401 Belvoir Rd.			



1

70 7893

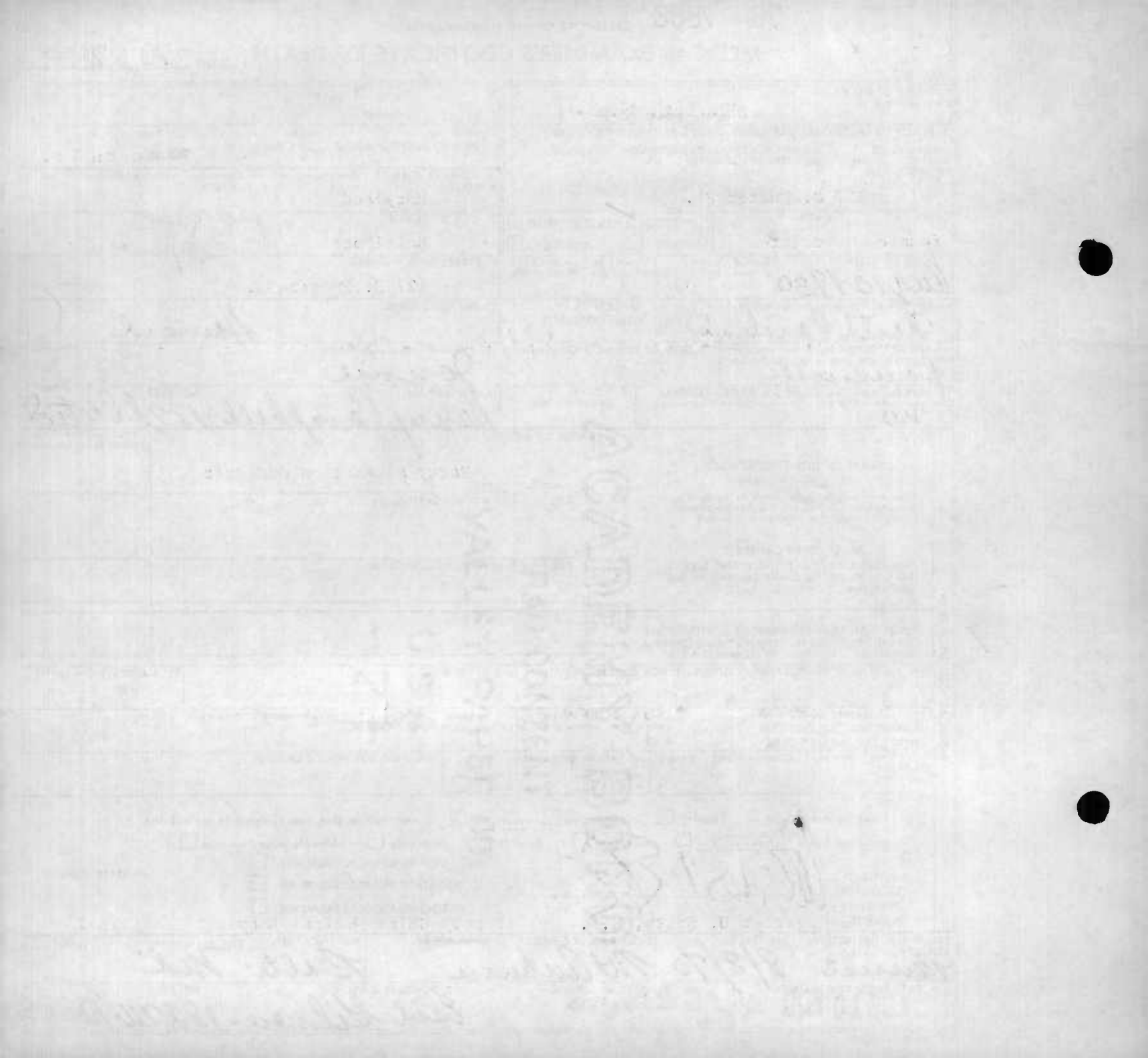
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7893

BIRTH NO.

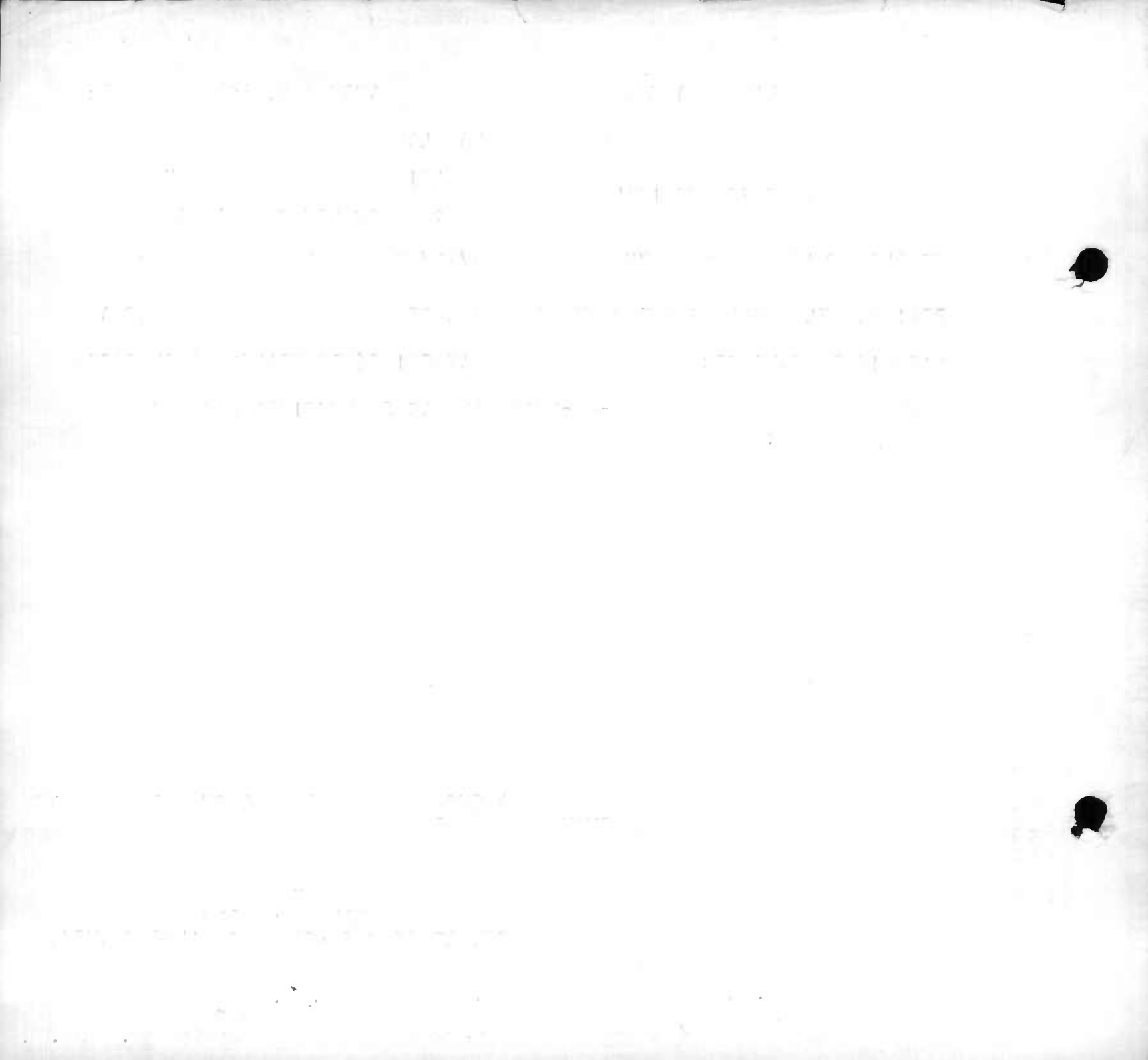
1. NAME OF DECEASED (Type or Print) Elizabeth Campbell		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 127 S. Exeter St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 4 70 8:30 a. m.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 302			
6. SEX female	7. RACE colored	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. CITY OR TOWN Baltimore
10. DATE OF BIRTH Aug 10 - 1930		11. AGE (In years last birthday) 39	12. INSIDE CITY LIMITS? Yes <input type="checkbox"/> No <input type="checkbox"/>
13. DATE OF BIRTH Aug 10 - 1930		14. AGE (In years last birthday) 39	15. STREET AND NUMBER 127 S. Exeter St.
16. BIRTH PLACE (State or foreign country) North Carolina		17. CITIZEN OF WHAT COUNTRY?	18. FATHER'S NAME Howard
19. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		20. KIND OF BUSINESS OR INDUSTRY	21. MOTHER'S MAIDEN NAME Jennie
22. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		23. SOCIAL SECURITY NO.	24. INFORMANT Henry Campbell - 127 S. Exeter St.
25. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty alteration of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
27. DATE OF OPERATION 2		28. CONDITION FOR WHICH OPERATION WAS PERFORMED	
29. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		30. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
31. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		32. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
33. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		34. HOW DID INJURY OCCUR?	
35. I certify that, held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
36. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		37. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner	
38. DATE SIGNED 8/5/70			
39. BURIAL CREMATION, REMOVAL (Specify) Burial		40. DATE 8/8/70	
41. NAME OF CEMETERY or CREMATORY Mt. Auburn		42. LOCATION (City, town, or county) (State) Balt. Md	
43. DATE REC'D BY HEALTH DEPT. AUG 10 1970		44. NAME OF REGISTRAR Earl Gilmore - 1827 W. North Ave	
45. FUNERAL DIRECTOR		46. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 7894</u>
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
LIND. MARTHA		AUGUST 7, 1970 1:00P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		A. STATE MARYLAND		
		B. COUNTY		
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 04/12/87		9. AGE (In years last birthday) 83		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
RETIREED SELF EMPL		GROCERY STORE		FRANCE
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME PIERRIE ROSENBERGER		
14. MOTHER'S MAIDEN NAME CATHERINE (NEE WEILER) ROSENBERGER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		
16. SOCIAL SECURITY NO. 820-02-2974		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS		
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE SEVERE DENYDRATION DUE TO, OR AS A CONSEQUENCE OF: ELECTROLYTE IMBALANCE, DUE TO (B) PERITONITIS - EMPHYEMA GALL BLADDER DUE TO, OR AS A CONSEQUENCE OF: (C) DIABETES MELLITUS
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from AUGUST 6 19 70 to AUGUST 7 19 70 that (I) (we) last saw the deceased alive on AUGUST 7 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.				
23A. SIGNATURE P. Boonswang M.D.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) DR. PRICHA BOONSWANG M.D.
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY
Burial		Aug. 10, 1970		New Cathedral Cem.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
AUG 10 1970		Robert E. Taylor, M.D.		21229
26A. ADDRESS		26B. ADDRESS		
BALTO, MD 21229		ST. AGNES HOSP; CATON & WILKENS AVES.		
27A. ADDRESS		27B. ADDRESS		
G, Truman Schwab		3512 Frederick Ave. Balto. Md.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 7895
1. NAME OF DECEASED (Type or Print) Charles A. Phelps		2. DATE AND HOUR OF DEATH 8-4-70 430 P		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY HOWARD C. CITY OR TOWN LAUREL D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2501 GORMAN ROAD		
5. SEX MALE	6. RACE CAUS	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/27/04	9. AGE (In years last birthday) 66 If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) editor		10B. KIND OF BUSINESS OR INDUSTRY newspaper		11. BIRTHPLACE (State or foreign country) OKLAHOMA
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Rufus Phelps		
14. MOTHER'S MAIDEN NAME Belle Reed		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 454-03-1975		17. INFORMANT Janet W. Phelps ADDRESS 2501 Gorman Rd Laurel Md		
18. 319.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: SUSPECTED (B) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF: (C) CHRONIC OBSTRUCTIVE PULMONARY DISEASE 23 YEARS 4 LOR PNEUMONIA		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 12:43 PM AUG 4 1970 to 5:30 PM AUG 4 1970 that (I) (we) last saw the deceased alive on AUG 4 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.				
23A. SIGNATURE Meyer R. Heyman M.D.		23B. DATE SIGNED 8/4/70		23C. PHYSICIAN'S NAME (Type) MEYER R. HEYMAN M.D.
23D. ADDRESS UNIV. HOSP.		24A. BURIAL CREMATION, REMOVAL (Specify) Cremeration		
24B. DATE 8-7-70		24C. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory		24D. LOCATION (City, town, or county) (State) Colman Manor Md.
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Donaldson J.H. Laurel Md



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 7896

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

LILY MONAGHAN

2. DATE
OF
DEATHKnown ☐

Month

Day

Year

Hour

M.

Estimated ☐

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

44 UNION MEMORIAL HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

August 5, 1970

6:37 A.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1203

6. SEX

Female

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

2/10/1887

10. AGE (in years
last birthday)

85 87

If Under 1 Yr. II Under 24 Hrs.
Months, Days, Hours, Min.

E. STREET AND NUMBER

2829 Gilford Avenue

11. BIRTHPLACE (State or foreign country)

BALTIMORE, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

WILLIAM STEWART

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOMEMAKER

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

CORA DEMLING

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, if unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

215505807

18. INFORMANT

ADDRESS

MRS. STEWART KELLY 2829 Gilford Ave

19.

41241

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/5/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

8/7/70

24C. NAME of CEMETERY or CREMATORY

NEW CATHEDRAL CEMT.

24D. LOCATION (City, town, or county)

FREDERICK RD. BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.

AUG 10 1970

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

MITCHELL WIEDERELD HOME

ADDRESS

6500 YR. Rd.

4E

Guilford Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 7897		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 70 7897	
1. NAME OF DECEASED (Type or Print) <u>Bounds, Wayne Alan</u>			2. DATE AND HOUR OF DEATH <u>7-29-70</u> <u>8:53 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Prince George</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland Hospital</u>			C. CITY OR TOWN <u>Laurel</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>10-12-53</u>		9. AGE (in years last birthday) <u>16</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Paul Bounds</u>		
14. MOTHER'S MAIDEN NAME <u>Ruth Hill</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>N.A.</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>PAUL BOUNDS - ABOVE</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u> <u>2 yrs.</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-23</u> 19 <u>70</u> to <u>7-29</u> 19 <u>70</u> that (I) (we) lost saw the deceased alive on <u>7-29</u> 19 <u>70</u> and that (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Wm. A. Blank M.D.</u> DEGREE				23B. DATE SIGNED <u>7-29-70</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-1-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Union Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Burtonville Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Valley M.D.</u>	
25C. FUNERAL DIRECTOR <u>Samuel J. Funeral Home</u>		25D. ADDRESS <u>Laurel Md.</u>			



1

70 7898

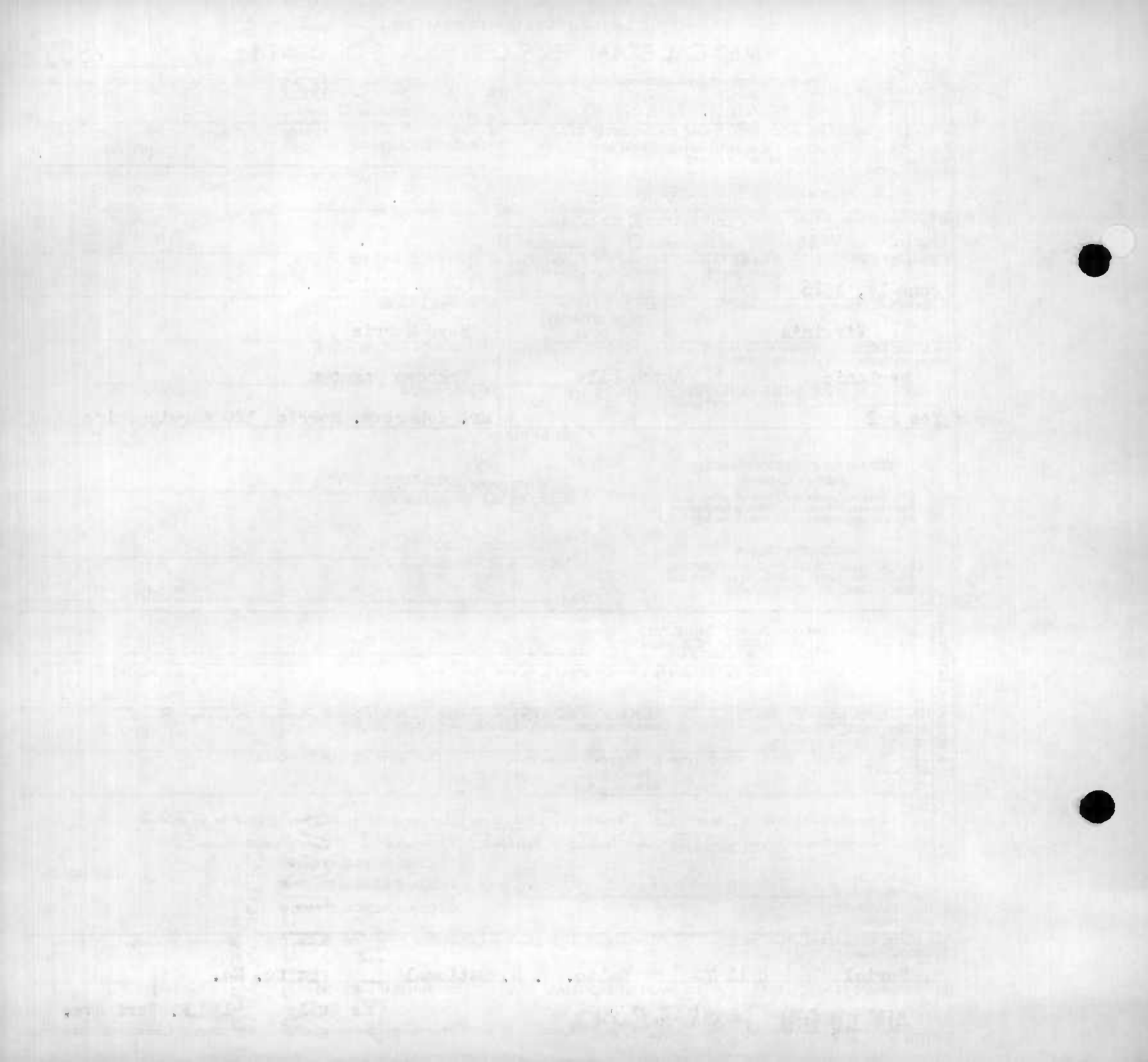
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7898

BIRTH NO.

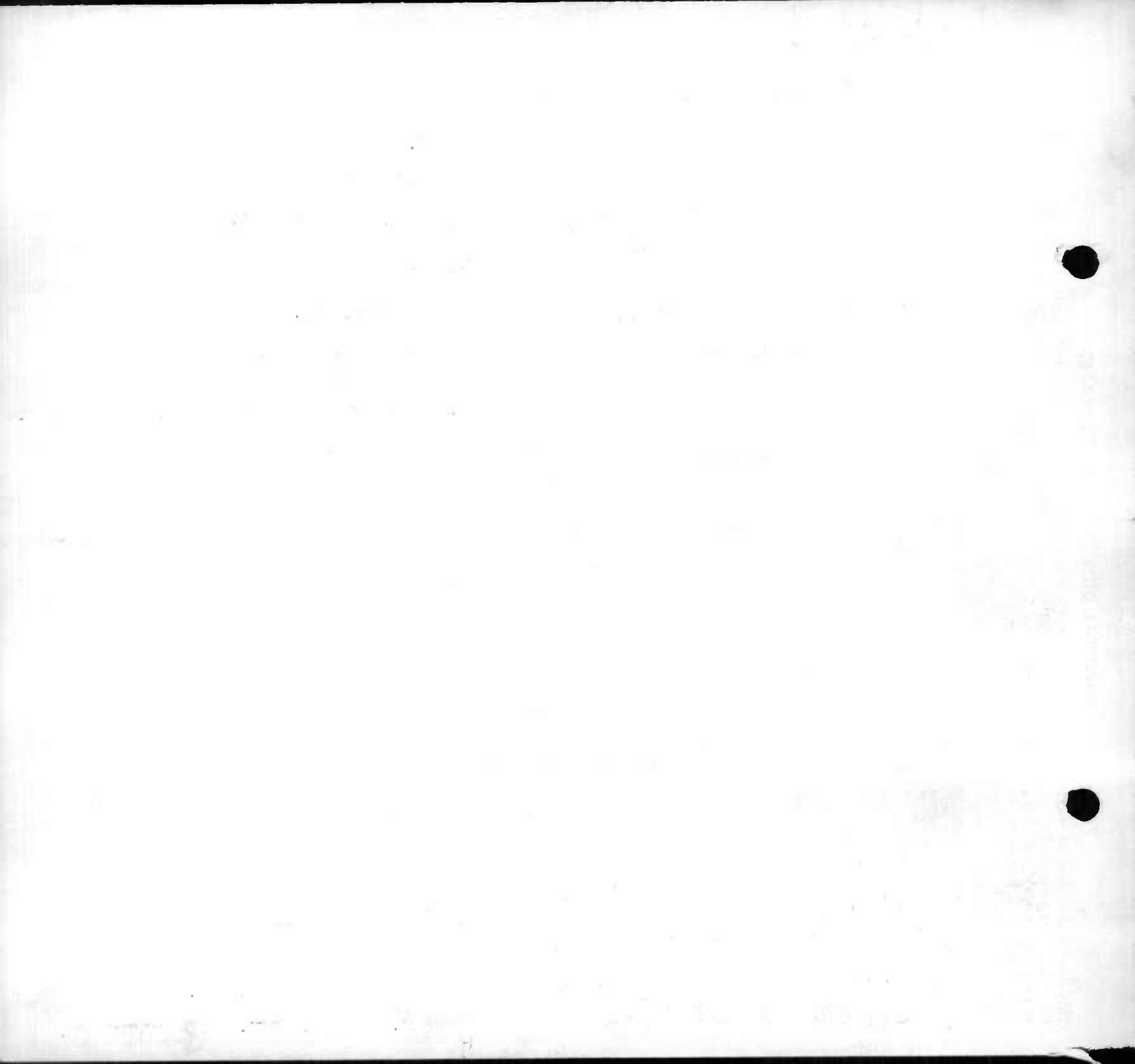
1. NAME OF DECEASED (Type or Print) BOYD H. MORRIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 6 1970 6:18 P. M.	
5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Md. B. COUNTY 2201		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH June 18, 1926		10. AGE (In years lost birthday) 44	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Boyd Morris		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic	
15. MOTHER'S MAIDEN NAME Unknown Unknown		16. KIND OF BUSINESS OR INDUSTRY Automobile	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mr. Robert W. Morris 120 Warwickshire Lane	
19. CAUSE OF DEATH 57101 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. chronic alcoholism OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes (PARTIAL)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE [Signature] M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8 11 70	
24C. NAME of CEMETERY or CREMATORY Balto. U. S. National		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Mc Cully		ADDRESS 130 E. Fort Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-636		70 7899		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7899	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Donald D. Carruthers</u>				2. DATE AND HOUR OF DEATH <u>8/4/70</u> <u>2:27 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37 MERCY Hospital</u>				A. STATE <u>Md.</u>		B. COUNTY <u>2403</u>	
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>				6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH <u>2/23/16</u>				9. AGE (in years last birthday) <u>54</u>		10. If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rigger</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Shipyard</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>David Carruthers</u>			
14. MOTHER'S MAIDEN NAME <u>Edna Marie Kelly</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>WW II</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mrs. Rita Carruthers</u>			
18. <u>44191</u> CAUSE OF DEATH				ADDRESS <u>104 E. Hamburg St</u>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertensive Shock.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
				(B) <u>Ruptured Aortic Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <u>Arterio</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>8/4/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>B</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>8/3/70</u> 19 to <u>8/4/70</u> 19 that (1) (we) last saw the deceased alive on <u>8/4/70</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>L. S. Ranganath</u>				23B. DATE SIGNED <u>8/4/70</u>		23C. PHYSICIAN'S NAME (Type) <u>L. S. RANGANATH, M.D., D.S.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/7/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>JOHN F. DENNY, INC.</u>		ADDRESS <u>715 Light St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7900</u>	
B-255 70 7900		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>ELMER E. BUCHANAN</u>		2. DATE AND HOUR OF DEATH <u>8-6-70</u> <u>13:30 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY OF MARYLAND HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>LINCOLN NURSING HOME 27 N. CAKEY ST.</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/22/0</u>	9. AGE (In years last birthday) <u>70</u>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Contracting</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>—</u>			
14. MOTHER'S MAIDEN NAME <u>—</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK.</u>			
16. SOCIAL SECURITY NO. <u>162-12-5867</u>		17. INFORMANT <u>JOHN FOX</u> ADDRESS <u>21227 1928 BELLE AVE</u>			
18. <u>413.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
(B) <u>UTI</u> DUE TO, OR AS A CONSEQUENCE OF:		(C) <u>ASCVD, SENILE DEMENTIA</u>		<u>UNDET.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NO</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>19 70</u> to <u>8-6</u> 19 <u>70</u> that (1) (we) last saw the deceased alive on <u>8-6</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jaime F. Casellas M.D.</u>		23B. DATE SIGNED <u>8-6-70</u>		23C. PHYSICIAN'S NAME (Type) <u>JAIME F. CASELLAS</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>08/10/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore City, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Walters Funeral Home</u>		25D. ADDRESS <u>Pratt & Stricker Streets 21227</u>			

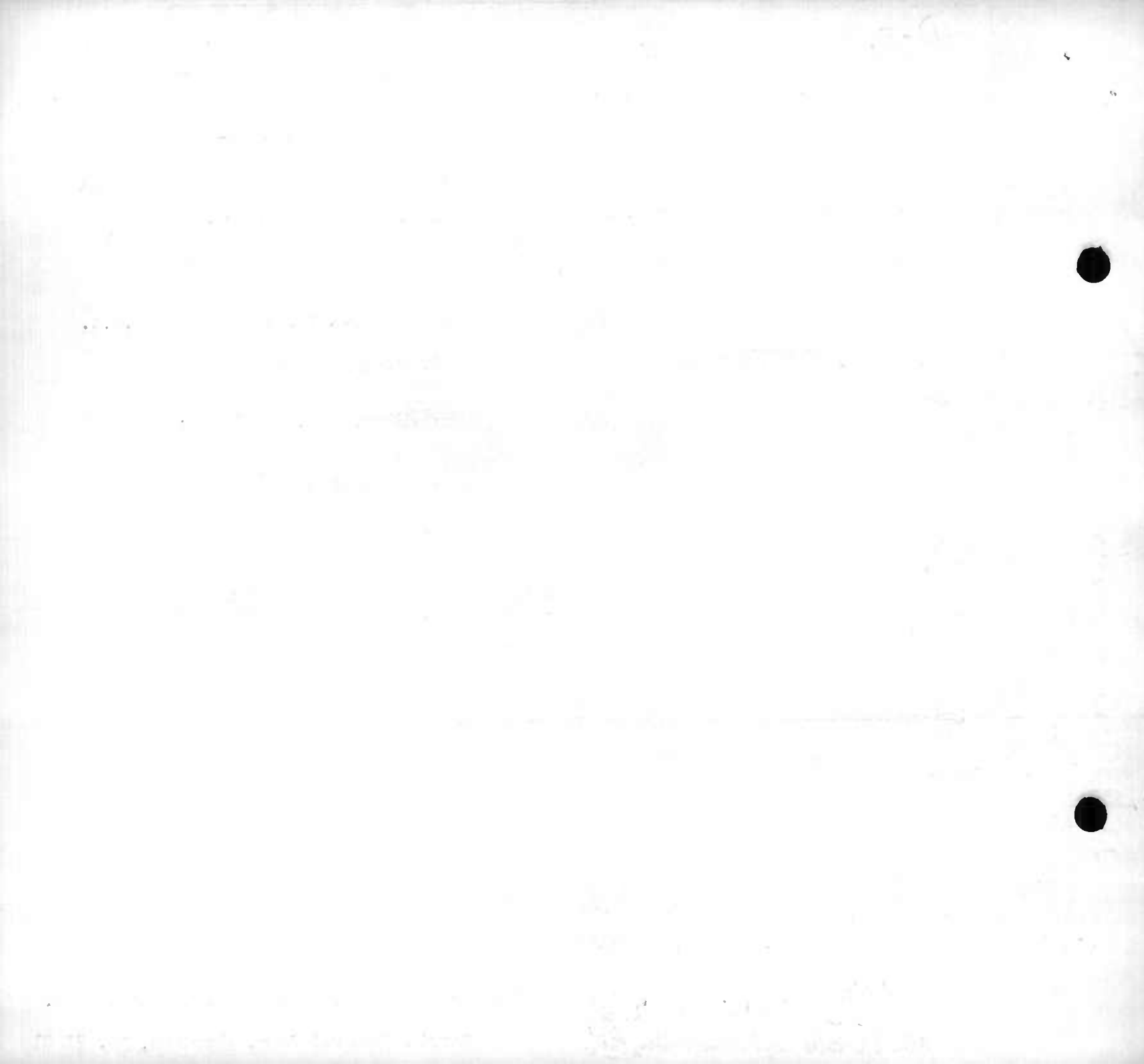
4E

1928 Belle Ave. Admitted To
Lincoln N.H. 5/12/70.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
W-362 70 7901					CERTIFICATE OF DEATH				
BIRTH NO. <i>W-362 70 7901</i>					REG. NO. <i>70 7901</i>				
1. NAME OF DECEASED (Type or Print) WITHERSPOON, Joel Lee					2. DATE AND HOUR OF DEATH 8/7/70 2:55 A. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital					A. STATE & COUNTY Maryland Harford				
					C. CITY OR TOWN Perryman		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
					E. STREET AND NUMBER Box 57 Perryman, Md.				
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/8/70	9. AGE (In years last birthday) 1	10. Under 1 Yr. Months Days 1 0		11. Under 24 Hrs. Hours Min. 0	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A				10B. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Havre de Grace, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John M. Witherspoon					14. MOTHER'S MAIDEN NAME Charlotte Brown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS John Witherspoon, Perryman, Maryland			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 753.21 Uremia Eagle-Barrett Syndrome With no detectable kidney, hydronephrosis & kidney premenstrual					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). kidney, hydronephrosis & kidney premenstrual									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Ray W. Tripp M.D.					23B. DATE SIGNED 8/7/70			23C. PHYSICIAN'S NAME (Type) Ray W. Tripp, M.D.	
23D. ADDRESS Johns Hopkins Hosp.									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10 Aug. 70		24C. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens		24D. LOCATION (City, town, or county) (State) Aberdeen, Harford County, Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Tarring Funeral Home, Aberdeen, Md. 21001					



FUNERAL DIRECTOR: IMPORTANT

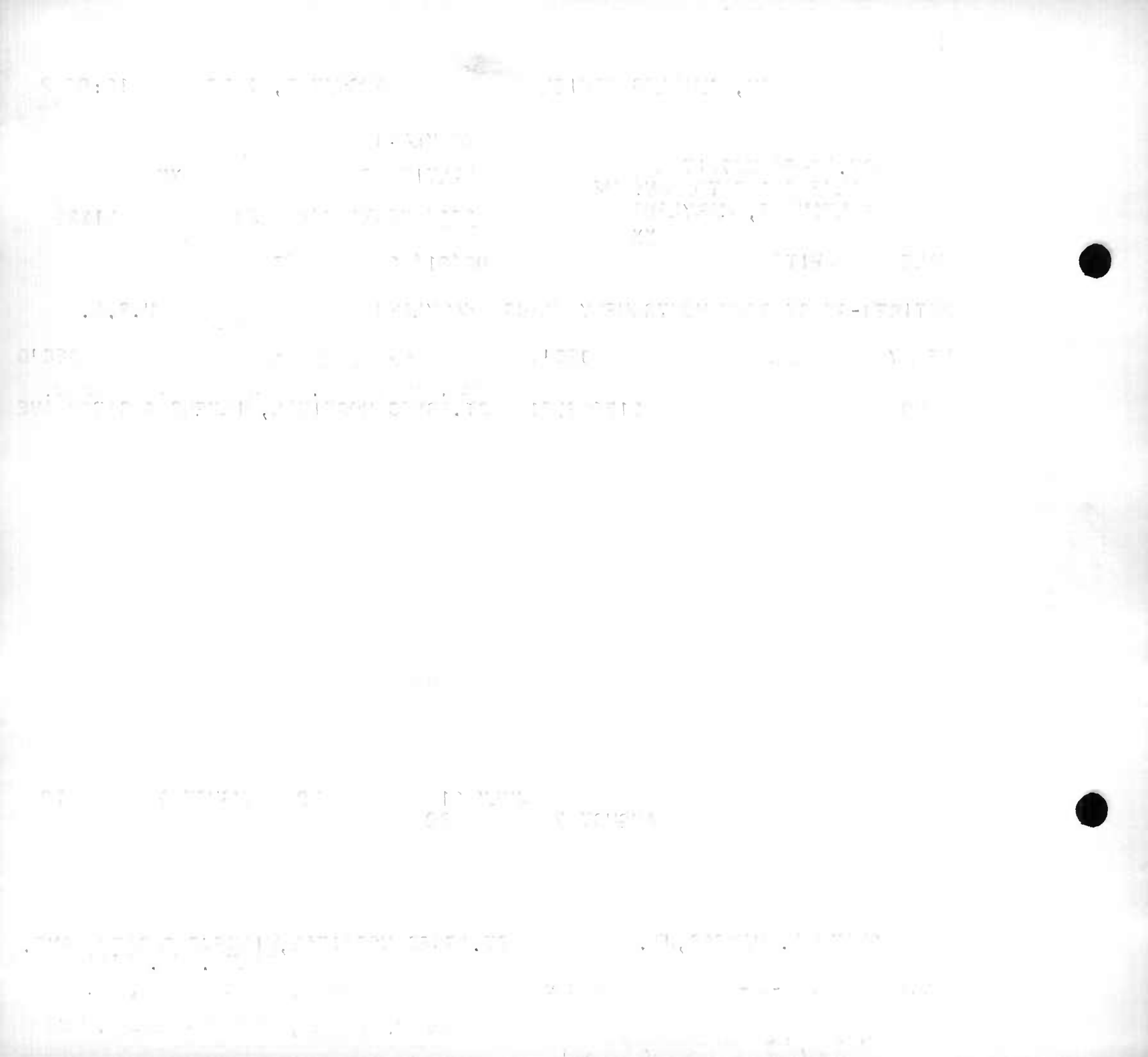
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
70 7902 CERTIFICATE OF DEATH					REG. NO. 70 7902				
1. NAME OF DECEASED (Type or Print) <u>John A. Miller</u>					2. DATE AND HOUR OF DEATH <u>Aug. 4, 1970</u> <u>12:15 A.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Gould Nursing Home</u>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Harford</u> C. CITY OR TOWN <u>Joppatowne</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>531 Eckhart Dr.</u>				
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1, 1887</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Luggage Shop</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>		11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>August Miller</u>			14. MOTHER'S MAIDEN NAME <u>Barbara Unknown</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>218-32-1713 A</u>			17. INFORMANT <u>Carl G. Miller 531 Eckhart Dr. Joppatowne Md.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Peripheral Circulatory collapse</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Cardiovascular Disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>years</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Angina pectoris; Chronic Emphysema; Chronic Brain Disease; Prost. Extremities.</u>									
19A. DATE OF OPERATION <u>8/12/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>5/26/67</u> to <u>8/4/70</u> , that (I) (we) lost saw the deceased alive on <u>11:00 P.M. 8/3/70</u> and that in (my) (we) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Albert B. Bradley</u>					DEGREE Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/5/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>ALBERT B. BRADLEY, M.D.</u>					23D. ADDRESS <u>4900 Belair Road 21206</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Aug. 7, 70</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1970</u>			25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Lassahn Funeral Home 7401 Belair Rd. 21236</u>				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-200 70 7903		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7903	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
BACH, CHARLES DANIEL			AUGUST 7, 1970 12:05 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE, MARYLAND			A. STATE MARYLAND		
			B. COUNTY		
5. SEX MALE			6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 09/01/82			9. AGE (In years last birthday) 87		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-STOCK ROOM			10B. KIND OF BUSINESS OR INDUSTRY MONTGOMERY WARDS		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME HENRY BACH DEC 'D		
14. MOTHER'S MAIDEN NAME Elizabeth Imhoff DEC 'D			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 217095751			17. INFORMANT Mrs. Gertrude M. Bach, 3538 Benzinger Rd. ST. AGNES HOSPITAL, WILKENS & CATON AVE		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No) NO					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from JULY 21 1970 to AUGUST 7 1970 that (I) (we) last saw the deceased alive on AUGUST 7 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donato A. Vargas Jr. M.D.					23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) DONATO A. VARGAS, JR.					23D. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-10-1970		24C. NAME OF CEMETERY OR CREMATORY Zion Cemetery	
24D. LOCATION Dorsey, Howard County, Md.		24E. DATE REC'D BY HEALTH DEPT. AUG 10 1970			
24F. NAME OF REGISTRAR Robert E. Taylor, M.D.		24G. FUNERAL DIRECTOR, ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			



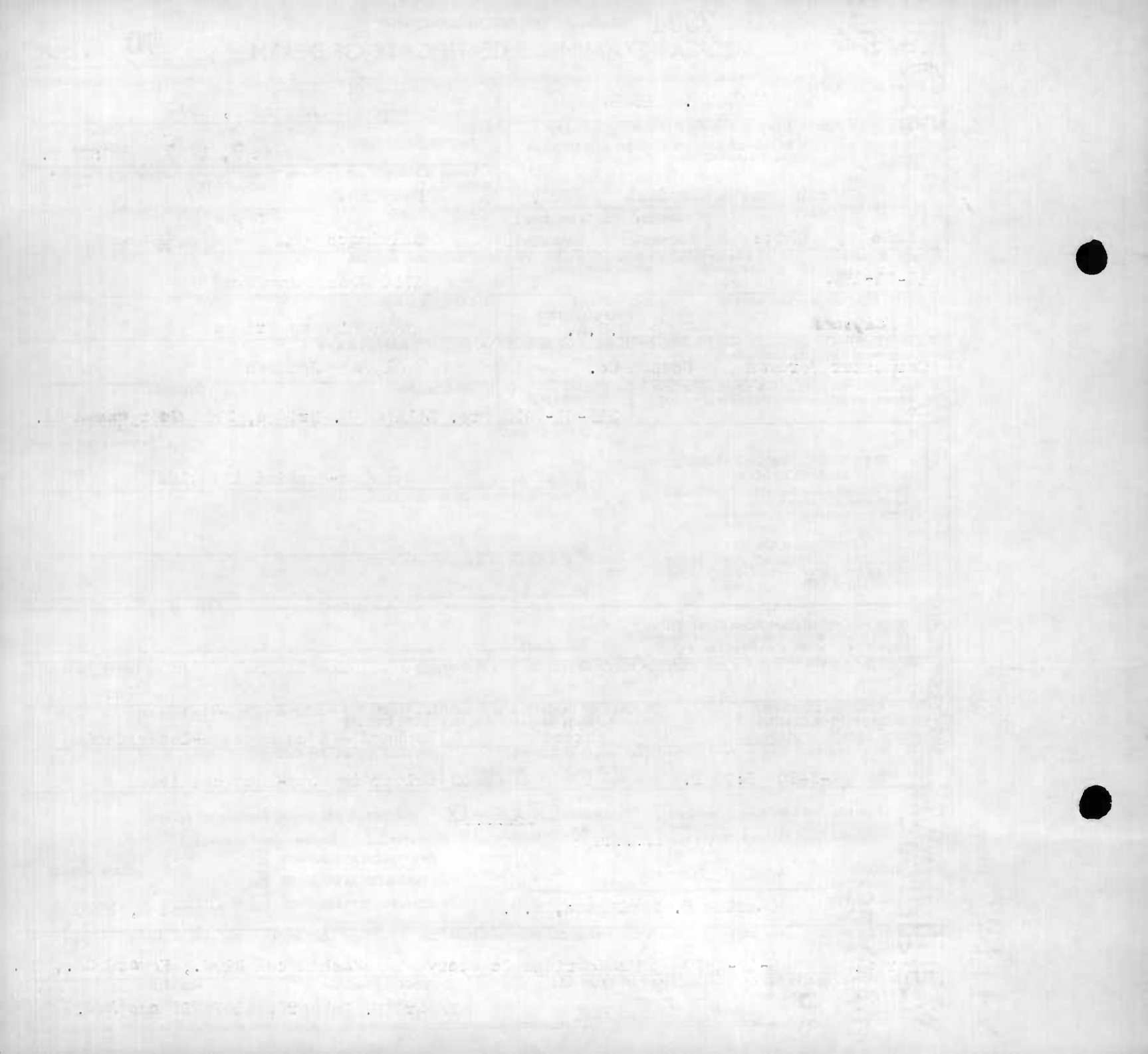
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 7904

BIRTH NO.

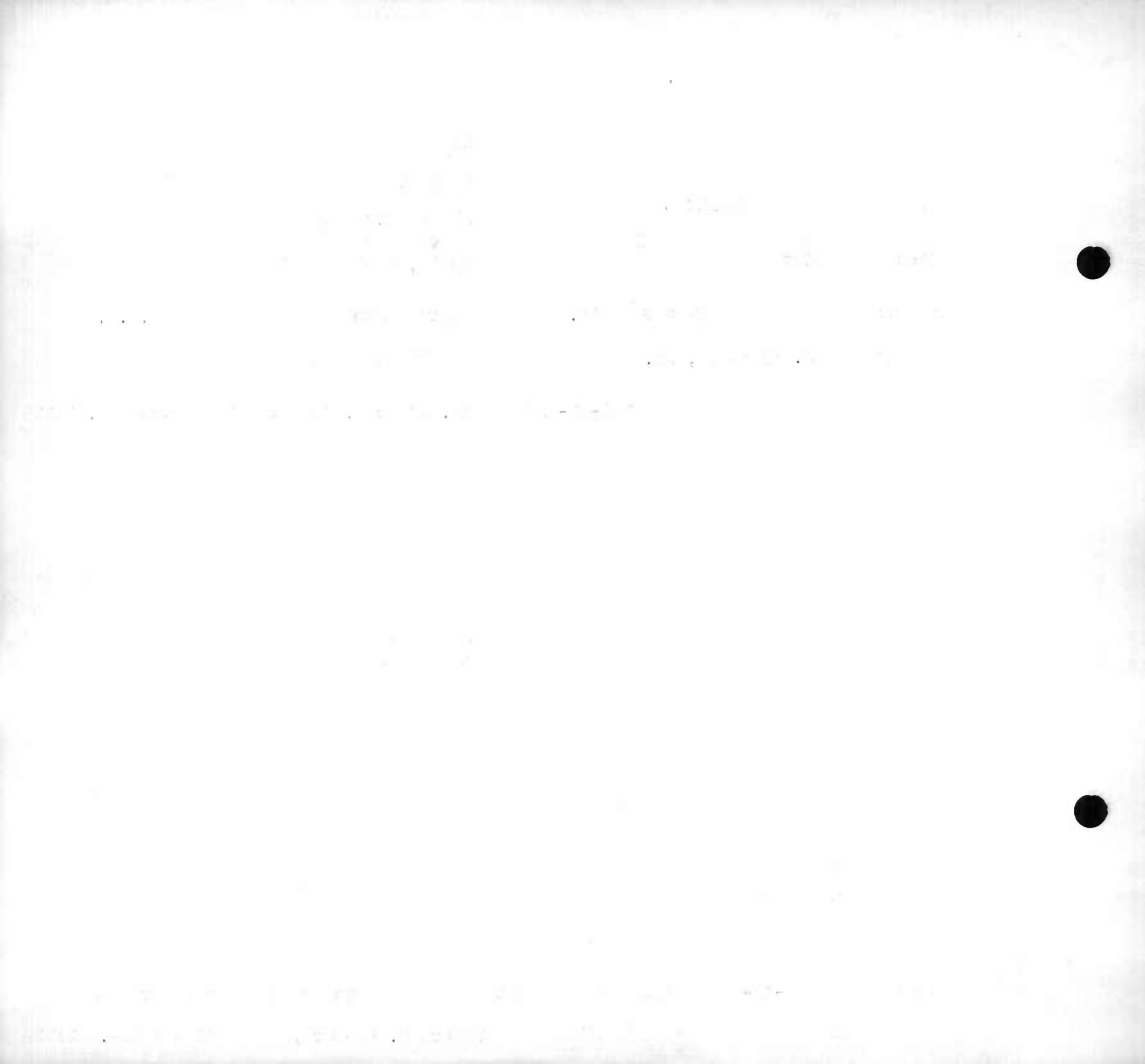
1. NAME OF DECEASED (Type or Print) THOMAS B. BRIDGE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year August 5, 1970	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour August 5, 1970 6:00 P. M.	
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY 2582
9. DATE OF BIRTH 11-21-1905	10. AGE (In years last birthday) 64	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Foreman		13. FATHER'S NAME John Thomas Bridge	
14B. KIND OF BUSINESS OR INDUSTRY Cotton Co.		15. MOTHER'S MAIDEN NAME Olive Johnson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215-01-7423	
18. INFORMANT Mrs. Lillian M. Bridge, 2736 Georgetown Rd.		ADDRESS 2736 Georgetown Road	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE Cerebro-cranial injuries DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 301 Lombard & Eden Streets-Intersection		22D. TIME OF INJURY (APPROX.) 8-5-70 5:30 P. m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Driver in auto-auto collision	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 6, 1970			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-10-1970	24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery	24D. LOCATION (City, town, or county) (State) Washington Blvd., Howard Co., Md.
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970	25B. NAME OF REGISTRAR Robert E. Farber, M.D.	25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21230	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

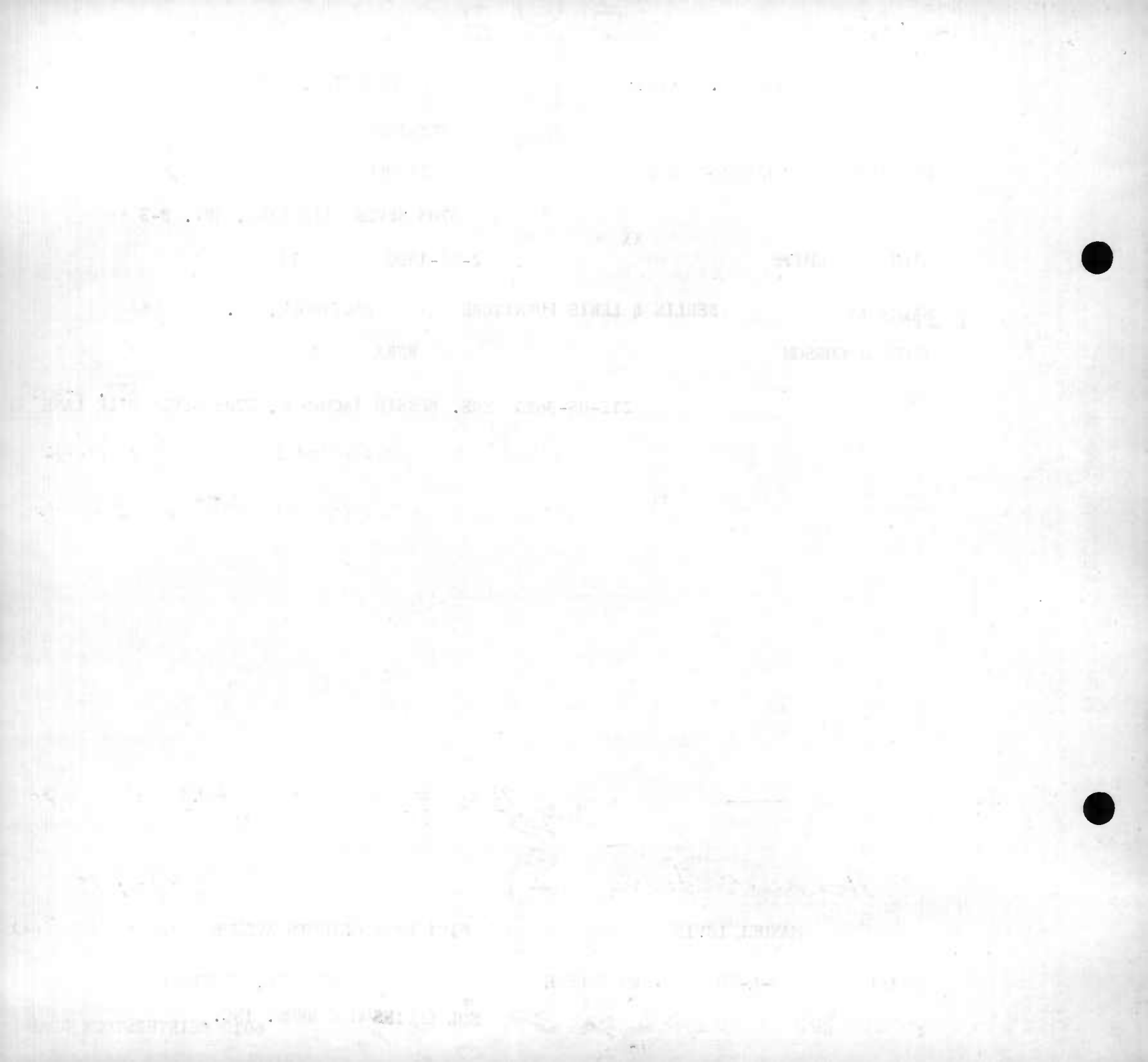
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7905</u>
S-600 70 7905		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Dorothy M. Sawyer</u>		2. DATE AND HOUR OF DEATH <u>8-7-70</u> <u>1:30 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2047</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy HOSPITAL</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>52 Benkert Avenue</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 19, 1913</u>	9. AGE (In years last birthday) <u>57</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Packer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Fava Food Co.</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John J. Phoenix, Jr.</u>		
14. MOTHER'S MAIDEN NAME <u>Maude Curtis</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>212-42-9534</u>		17. INFORMANT <u>Mrs. Aimee E. Snyder, 52 Benkert Ave. 21229</u>		
18. <u>130X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Esophagus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pneumonia</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>10 days</u>		
(C) <u>Bronchoesophageal fistula</u>		<u>10 days</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>July 25</u> 19 <u>70</u> to <u>August 7</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>August 7</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Boo Kean Kim</u>		23B. DATE SIGNED <u>8/7/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>Boo Kean Kim</u>		23D. ADDRESS <u>Mercy Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-10-1970</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greenhill Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Greensboro, North Carolina</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

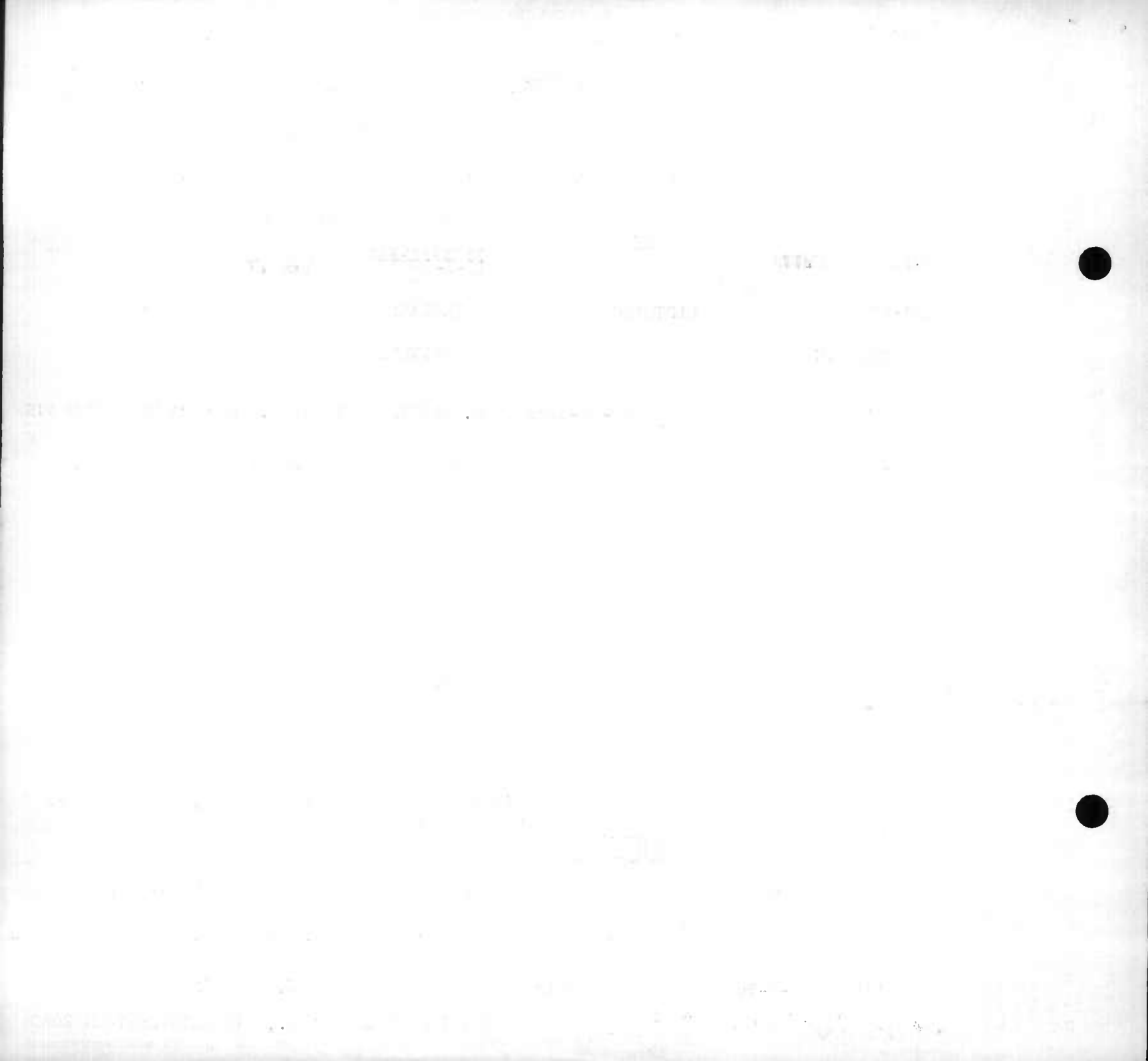
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7906	
J-212		70 7906		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MILTON A. JACOBSON		AUGUST 5, 1970 5 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		5. STATE 6. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		C. CITY OR TOWN	
PLEASANT MANOR NURSING HOME		BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
90		E. STREET AND NUMBER		3703 SEVEN MILE LANE, APT. B-5 #8	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2-22-1899	71	SALESMAN
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		BERLIN & LEWIS FURNITURE		BALTIMORE, MD.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JACOB JACOBSON		REBA ?		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		212-05-3685		MRS. BESSIE JACOBSON, 3703 SEVEN MILE LANE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
412.31		Cerebral Thrombosis		2 week	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		arteriosclerotic Heart Disease	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		2 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		none	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White <input type="checkbox"/> Nat White <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 9 1968 to Aug 5 1970, that (I) (we) last saw the deceased alive on Aug 5 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Manuel Levin		8/5/70		MANUEL LEVIN	
23D. ADDRESS		23E. FUNERAL DIRECTOR		23F. ADDRESS	
6101 PARK HEIGHTS AVENUE		SOL LEVINSON & BROS. INC.		6010 REISTERSTOWN ROAD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		8-6-70		MIKRO KODESH	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)		24F. DATE REC'D BY HEALTH DEPT.	
BALTIMORE, MARYLAND				AUG 10 1970	
25A. NAME OF REGISTRAR		25B. NAME OF REGISTRAR		25C. NAME OF REGISTRAR	
Robert E. Taylor, M.D.		Robert E. Taylor, M.D.		Robert E. Taylor, M.D.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7907	
BIRTH NO. R-153 70 7907		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Harry RABINOWITZ			2. DATE AND HOUR OF DEATH 8-4-70 7,40 a. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI Hospital of Baltimore 42			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE & COUNTY Md. Balto C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5514 RUBIN Ave.		
5. SEX MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>		6. RACE WHITE <input checked="" type="checkbox"/> BLACK <input type="checkbox"/> OTHER <input type="checkbox"/>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH XXXXXX 12-8-1902		9. AGE (In years last birthday) XX 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR	
11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? USA		10B. KIND OF BUSINESS OR INDUSTRY CLOTHING	
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 060-09-2222		17. INFORMANT ADDRESS MRS. BESSIE RABINOWITZ, 5514 RUBIN AVENUE #15	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ca of the LUNG (B) DUE TO, OR AS A CONSEQUENCE OF: (C) </div> <div style="width: 5%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years </div> </div>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Infolly medical examined) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb. 19 69 to August 19 70 that (I) (we) last saw the deceased alive on 7-31-19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> We <input type="checkbox"/> did <input type="checkbox"/> did not view the body after death.					
23A. SIGNATURE Ardaiz				23B. DATE SIGNED 8-4-70	
23C. PHYSICIAN'S NAME (Type) Jose ARDAIZ				23D. ADDRESS 7 OBERLIN COURT, Towson, Md. 21204	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-5-70		24C. NAME of CEMETERY or CREMATORY WORKMENS CIRCLE	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970			
25B. NAME OF REGISTRAR Robert E. Fisher, Jr.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 7908	
1. NAME OF DECEASED (Type or Print) FRANK COHEN			2. DATE AND HOUR OF DEATH August 5, 1970 2:32 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 2719		
5. SEX MALE			6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MFG.			10B. KIND OF BUSINESS OR INDUSTRY WHISKEY		11. BIRTHPLACE (State or foreign country) RUSSIA
13. FATHER'S NAME AVIGADA COHEN			14. MOTHER'S MAIDEN NAME RACHAEL ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 217-05-2372		17. INFORMANT MRS. LENA COHEN, 3409 GLEN AVENUE #21215
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardio Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF: massive myocardial infarction (B) Arteriosclerotic CVD DUE TO, OR AS A CONSEQUENCE OF: (C) Gen + Cor Pulm Arteriosclerotic		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 10/16/67 to 8/15/70 19 70 that (I) (we) last saw the deceased alive on 8/15/70 19 70 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE Willard Applefeld				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) WILLARD APPLEFELD				23D. ADDRESS 6615 REISTERSTOWN ROAD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-5-70		24C. NAME OF CEMETERY or CREMATORY MARYLAND LODGE	
24D. LOCATION ROSEDALE, MARYLAND		24E. DATE REC'D BY HEALTH DEPT. AUG 10 1970			
24F. NAME OF REGISTRAR Robert E. Taylor, M.D.		24G. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

ATTEST

WITNESSES

NOTARY

STATE

COUNTY

Subscribed and sworn to before me this 10th day of July 1907

Carrie Chapman Cattell
President of the National
Association of Women
Suffragists

8/12/00

10/10/07

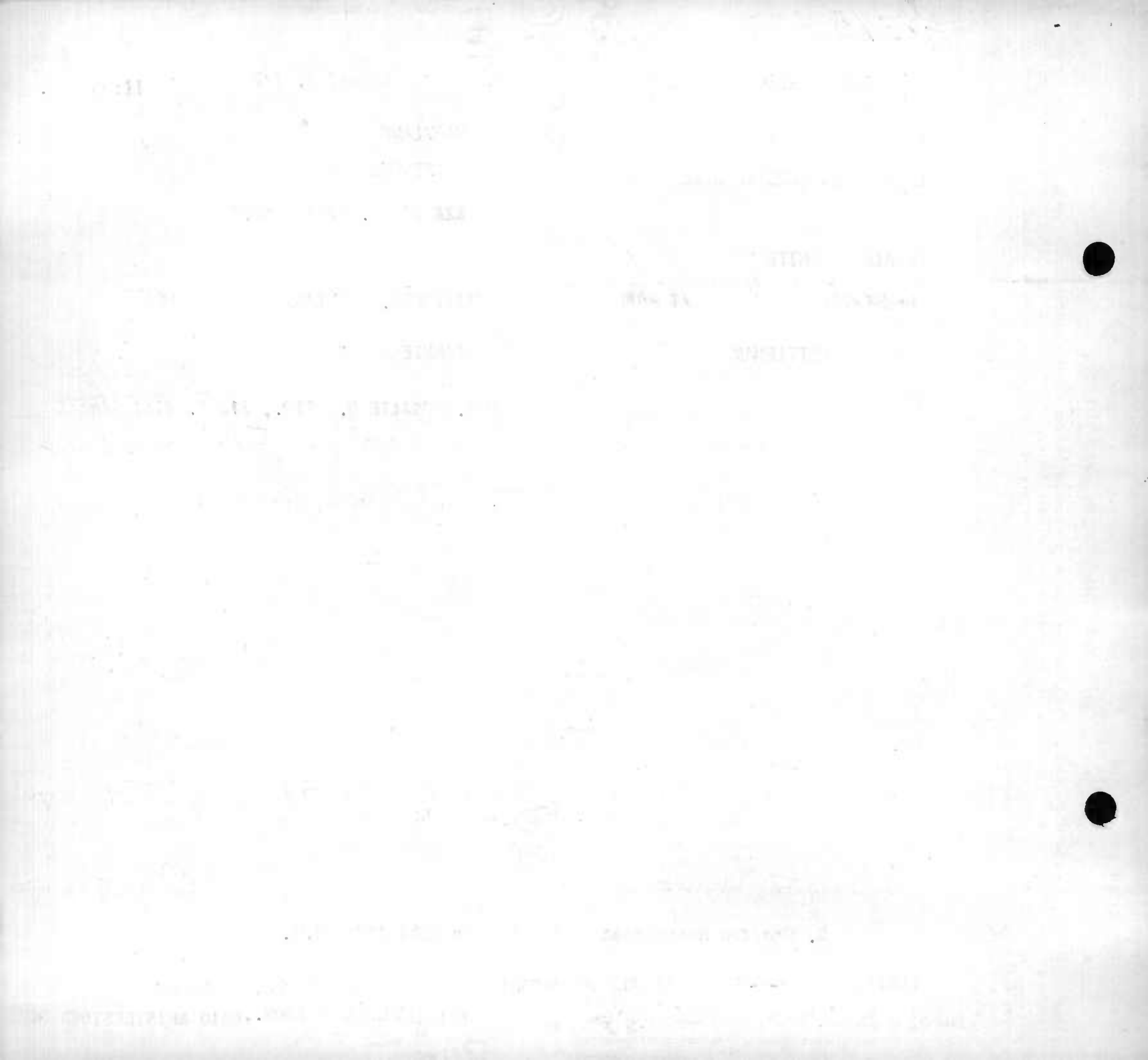
8/12/00

X

Carrie Chapman Cattell

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

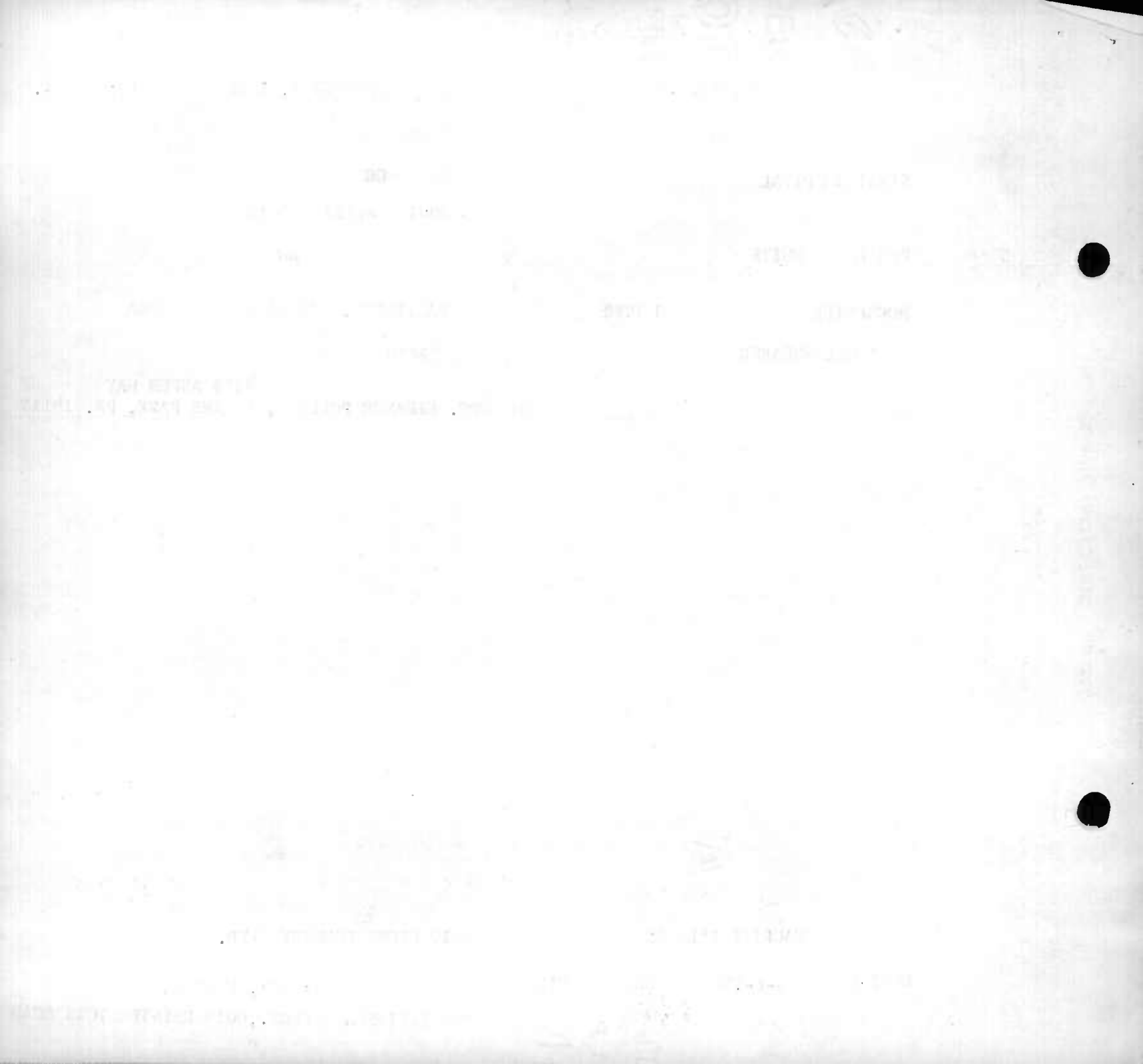
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7909	
BIRTH NO. H-345		70 7909		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Leida Kelba Hettleman			2. DATE AND HOUR OF DEATH August 4, 1970 11:35 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LONG GREEN NURSING HOME			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 901 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 888 810 E. 41st Street		
5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 89 9. AGE (In years last birthday) 89 If Under 1 Yr. Months: Days: Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10B. KIND OF BUSINESS OR INDUSTRY AT HOME 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ? HETTMAN			14. MOTHER'S MAIDEN NAME FANNIE ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. ROSALIE H. OTTO., 810 E. 41st Street ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.91 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Coronary Sclerotic Heart Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis (generalized) (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Days 4 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 5, 1957 to August 4, 1970, that (I) (we) lost saw the deceased alive on August 14, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Grafton Hersperger				23B. DATE SIGNED August 4, 1970	
23C. PHYSICIAN'S NAME (Type) W. Grafton Hersperger				23D. ADDRESS Medical Arts Bldg.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-6-70		24C. NAME OF CEMETERY or CREMATORY HEBREW FRIENDSHIP	
24D. LOCATION BALTIMORE, MARYLAND		24E. ADDRESS (City, town, or county) (State)			
25A. DATE RECD BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

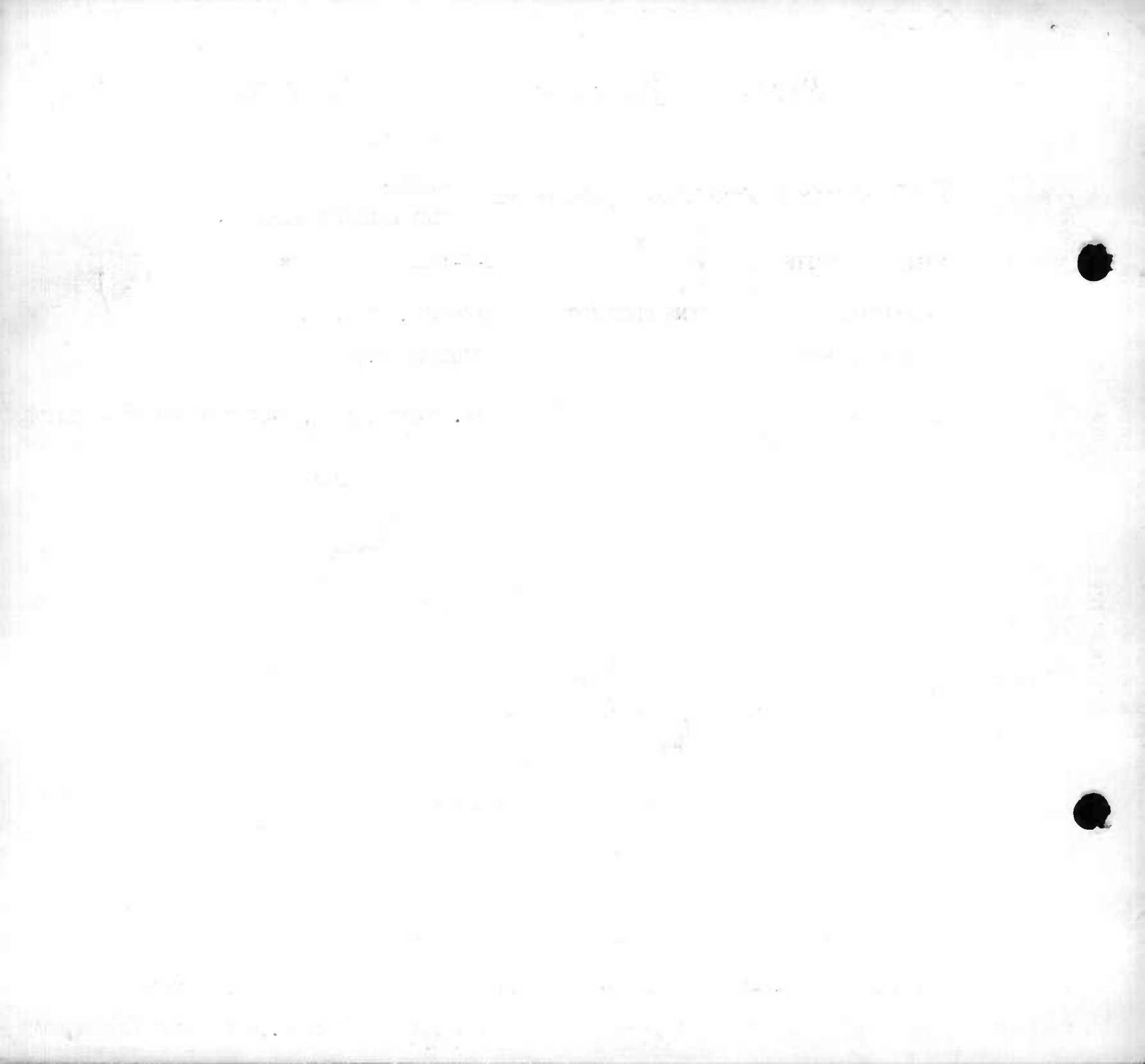
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7910	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) HELEN SHEARER				2. DATE AND HOUR OF DEATH AUGUST 5, 1970 12:35 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL 42				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2720 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4001 FORDLEIGH ROAD	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 60	9. AGE (In years lost birthday) 60	If Under 1 Yr. Months: <input type="checkbox"/> Days: <input type="checkbox"/> If Under 24 Hrs. Hours: <input type="checkbox"/> Min: <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME SAMUEL SHEARER				14. MOTHER'S MAIDEN NAME SARAH ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT MRS. ELEANOR POLLOCK, ELKINS PARK, PA. 19117	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.21 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH Acute cerebrovascular accident (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive art. scl. cv. disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hr 8 hr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0 no		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED no		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) no		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/5 19 70 to 8/6 19 70, that (I) (we) lost saw the deceased alive on 8/5 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Maurice Feldman				23B. DATE SIGNED 8/5/70	
23C. PHYSICIAN'S NAME (Type) MAURICE FELDMAN				23D. ADDRESS 6610 CROSS COUNTRY BLVD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-6-70		24C. NAME OF CEMETERY or CREMATORY SHAAREI TFILOH	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970			
25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

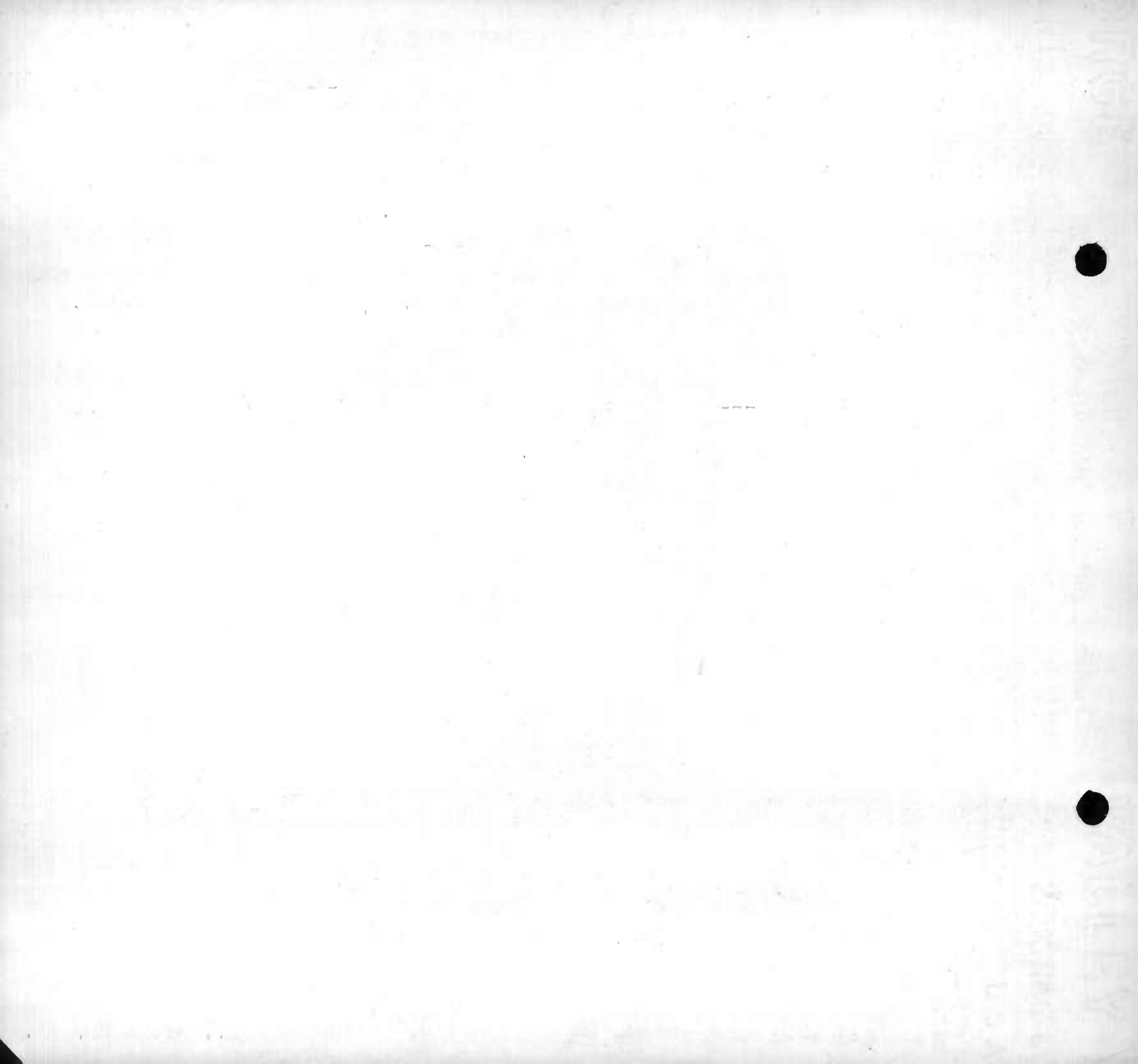
BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. <u>70 7911</u>	
D-625 70 7911		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>ROBERT DRAGON</u>		2. DATE AND HOUR OF DEATH <u>8-5-70</u> <u>1:40</u> PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Balto.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE JOHNS HOPKINS HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>4107 COLONIAL ROAD</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-3-1922</u>	9. AGE (in years last birthday) <u>48</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EXECUTIVE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>MENS CLOTHING</u>		11. BIRTHPLACE (State or foreign country) <u>BROOKLYN, NEW YORK</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>BENNETT DRAGON</u>			
14. MOTHER'S MAIDEN NAME <u>PAULINE GOTTLIEB</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>394-01</u>		17. INFORMANT <u>MRS. SONIA DRAGON, 4107 COLONIAL ROAD #21208</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Asystole during</u>		CAUSE OF DEATH <u>Asystole during</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Insufficiency</u>			
		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Porter Valve Disease</u>			
		(C) <u>Myocardial Insufficiency</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Pulmonary edema</u>					
19A. DATE OF OPERATION <u>15 Aug 70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Porter Valve Disease</u>		20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>31 Jul 70</u> 19 <u>70</u> to <u>5 Aug</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>5 Aug</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert D. Pipkin</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6 Aug 70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert D. Pipkin</u>		23D. ADDRESS <u>Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8-6-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>OHEB SHALOM MEMORIAL PARK</u>	
24D. LOCATION (City, town, or county) <u>REISTERSTOWN, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>			



FUNERAL DIRECTOR: IMPORTANT

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<div style="display: flex; justify-content: space-between;"> F-455 70 7912 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="text-align: center;"> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2> </div>		<div style="display: flex; justify-content: space-between;"> REG. NO. 70 7912 </div>	
1. NAME OF DECEASED (Type or Print) CHARLES FLEMINGS		2. DATE AND HOUR OF DEATH 8-2-70 7:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BOLTON HILL NURSING CENTER		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 401 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 425 N. EUTAW	
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-10-17
9. AGE (In years last birthday) 53		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10B. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL	
11. BIRTHPLACE (State or foreign country) MANAKIN, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME JUNUIS FLEMING		14. MOTHER'S MAIDEN NAME LAUNA HARRIS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ---	
17. INFORMANT ADMISSION RECORD		ADDRESS	
18. 436.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive encephalopathy (B) Coronary disease DUE TO, OR AS A CONSEQUENCE OF: (C)	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5/20 5/20			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/27 19 70 to 8/2 19 70 , that (I) (we) last saw the deceased alive on 8/2 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE [Signature]		23B. DATE SIGNED 8/3/70	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT MD		23D. ADDRESS 2 E. Rensselaer St. Baltimore, MD	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/7/70	
24C. NAME OF CEMETERY or CREMATORY PITTMAN		24D. LOCATION (City, town, or county) (State) MANAKIN GOOCHLAND VA	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Fisher MD	
25C. FUNERAL DIRECTOR CHILES FUNERAL HOME		ADDRESS 2100 FAIRMOUNT AVE., RICHMOND, VA.	



G-6501

70 7913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

70 7913

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JOHN H. GRAHAM.

2. DATE AND HOUR OF DEATH

8-6-70

8:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE

B. COUNTY

Maryland

U.S.A

2002

C. CITY OR TOWN

Baito

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

10 N Pulaski ST

5. SEX

M

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

3-31-06

9. AGE (In years last birthday)

64

If Under 1 Yr.

Months: Days:

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

James H. Graham

14. MOTHER'S MAIDEN NAME

Minnie Heppeman

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL SECURITY NO.

212-07-3303

17. INFORMANT

Mrs Catherine Bickel

ADDRESS

10 N. Pulaski ST
Baito, Md.

18.

250.91

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Heart and Renal Failure

days

(B) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Diabetes and diabetic gangrene of the Rt. leg

year

(C) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Myocardial infarct

days

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

3-7-12-70

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Gangrene of leg

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-12-1970 to 8-6-1970 and that (I) (we) last saw the deceased alive on 8-6-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

K. Zekry

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

8-6-70

23C. PHYSICIAN'S NAME (Type)

KAMAL

ZEKRY

DEGREE

23D. ADDRESS

Bon SECOURS Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8/10/70

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem.

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 10 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

George L. Schwab, Inc. Baito., Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

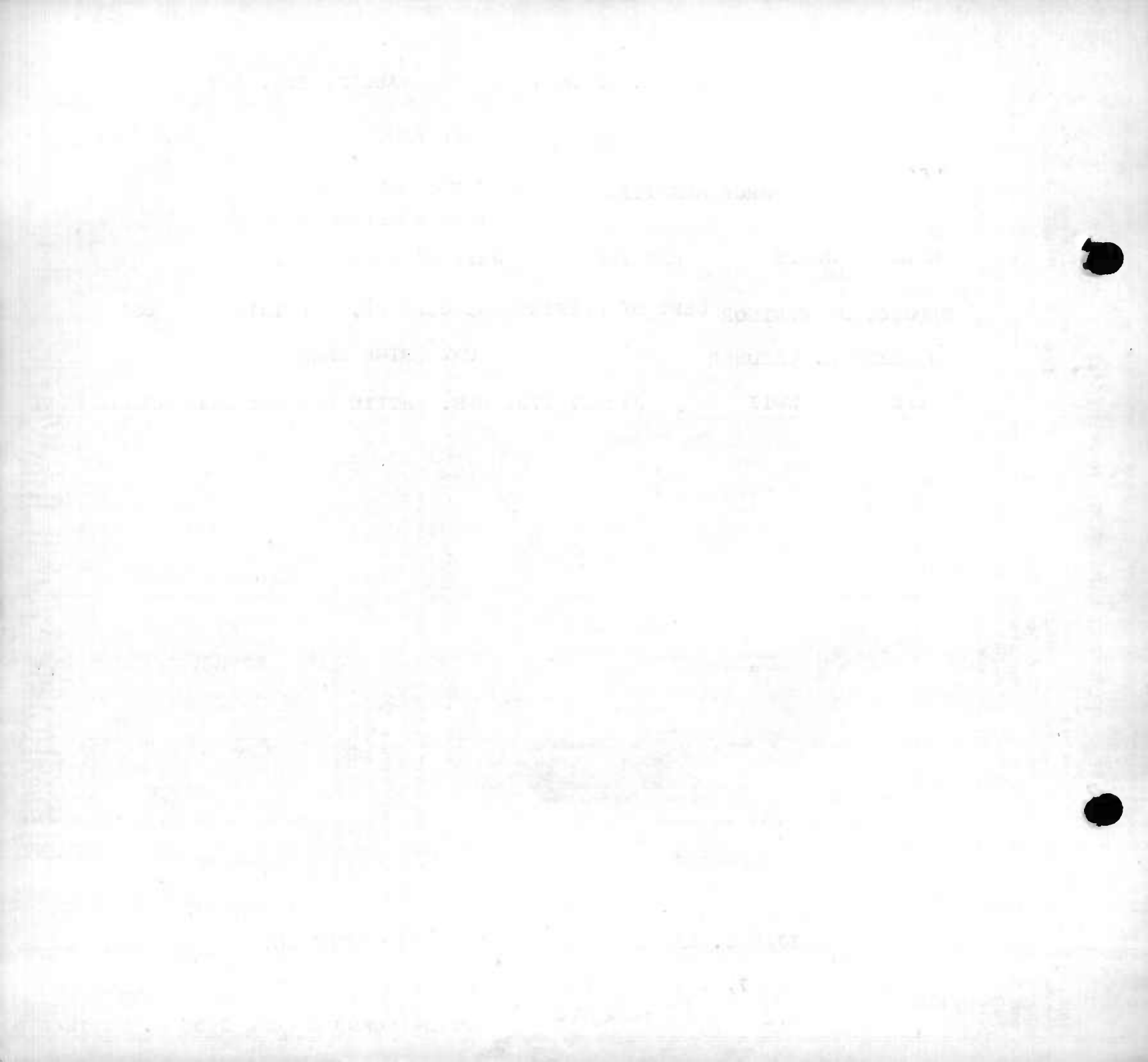
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. The first part of the
document is a list of
the names of the persons
who were present at the
meeting.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

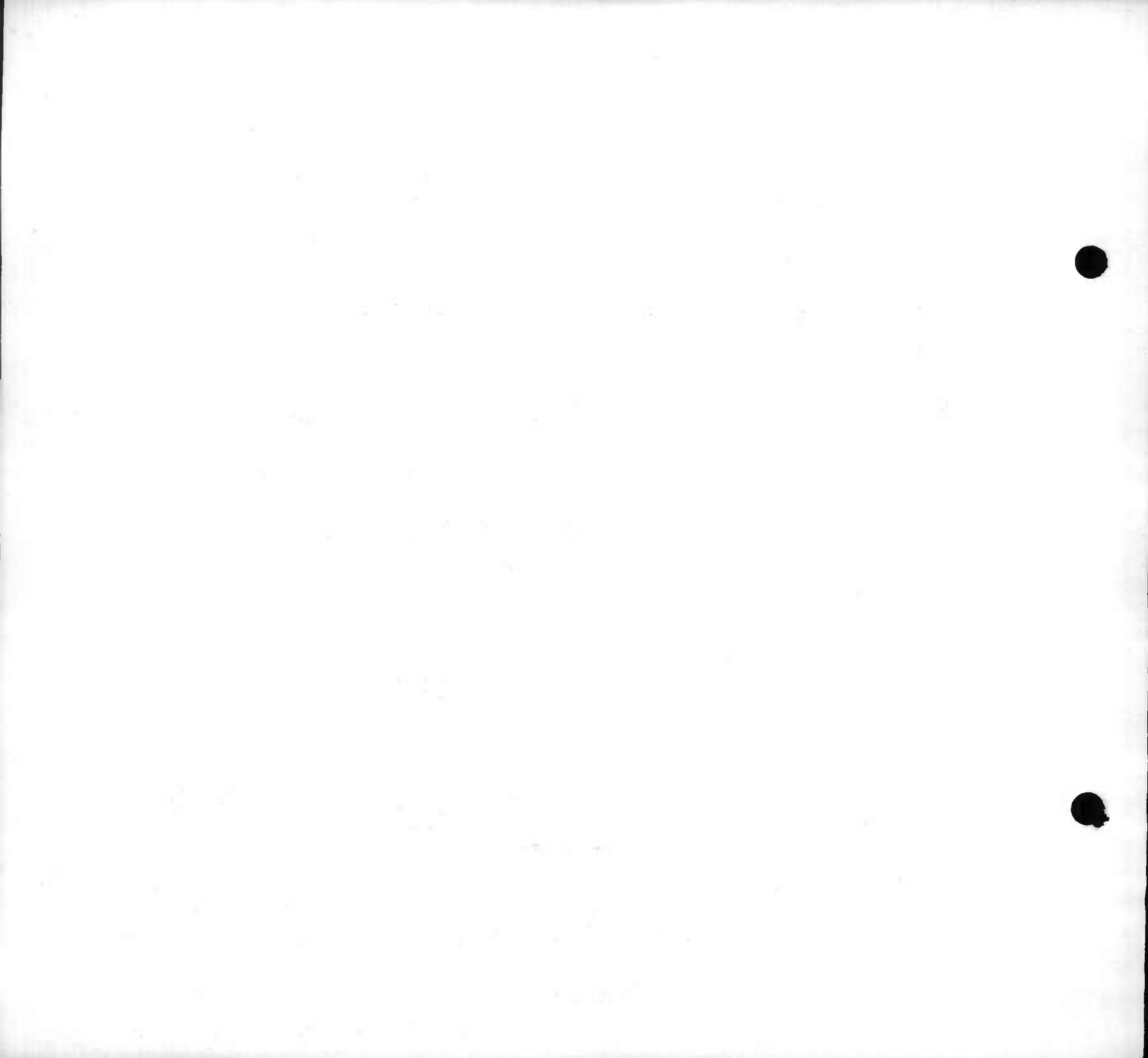
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		70 7914		70 7914	
M.E. CASE NO.		70 7914		70 7914	
1. NAME OF DECEASED (Type or Print)		WILLIAM M. GARDNER		2. DATE AND HOUR OF DEATH AUGUST 3rd, 1970 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL		A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1919 WHEELER AVE			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH July 21, 1909	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROJECT SUPERVISOR		10B. KIND OF BUSINESS OR INDUSTRY DEPT OF HOUSING		11. BIRTHPLACE (State or foreign country) GLOUCESTER, VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WILLIAM H. GARDNER		14. MOTHER'S MAIDEN NAME CATHERINE LAWS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 218-07-1762		17. INFORMANT MRS. MATTIE GARDNER 1919 WHEELER AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) ASHD & probable acute cardiac arrhythmia or myocardial infarction (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Elijah B. Saunders MD		23B. DATE SIGNED 8/7/70		23C. PHYSICIAN'S NAME (Type) R. T. Sinoat	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE AUG 7, 1970		24C. NAME of CEMETERY or CREMATORY BALTIMORE NATIONAL CEM	
24D. LOCATION BALTIMORE, MARYLAND		24E. NAME of REGISTRAR Robert E. Taylor, R.D.		24F. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME of REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 7915</u>	
BIRTH NO. <u>70 7915</u>					
1. NAME OF DECEASED (Type or Print) <u>LLOYD, John</u>		2. DATE AND HOUR OF DEATH <u>8/6/70</u> <u>12:20 P. M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 The Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution's residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BRA 3</u> <u>1604</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>113 91 73 AS 10</u> <u>1927 Harlem Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/6/03</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motor Operator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Sparrow Point</u>		11. BIRTHPLACE (State or foreign country) <u>Camden South Carolina</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Charles Lloyd</u>		14. MOTHER'S MAIDEN NAME <u>Kitty Anderson</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-07-9817</u>		17. INFORMANT <u>Mrs. Margaret Lloyd</u> ADDRESS <u>1927 Harlem Avenue</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>185X I</u> <u>CARDIAC ARREST</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> <u>METASTATIC CARCINOMA OF PROSTATE</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIAC ARREST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12:25</u>	
(B) DUE TO, OR AS A CONSEQUENCE OF: <u>METASTATIC CARCINOMA OF PROSTATE</u>		(C) _____		_____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <u>31 Jul 1970</u> to <u>6 Aug 1970</u> that (I) () last saw the deceased alive on <u>6 Aug 1970</u> and that in (my) () opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Henry A. Wise II</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6 Aug 70</u>	
23C. PHYSICIAN'S NAME (Type) <u>HENRY A. WISE MD</u>		23D. ADDRESS <u>Johns Hopkins Hosp.</u>			
24A. BURIAL (CREMATION), REMOVAL (Specify)	24B. DATE <u>8/10/70</u>	24C. NAME OF CEMETERY or CREMATORY <u>Bingham Chapel Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Westfield South Carolina</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Jarboe, M.D.</u>		25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME 3035 W. NORTH AVE</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>T-552</u>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7916</u>			
1. NAME OF DECEASED (Type or Print)				WILLIAM D. THEIMONGE				2. DATE AND HOUR OF DEATH <u>August 7 1970</u> <u>2:40 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION <u>37</u> <u>Mercy Hospital</u>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE <u>Maryland</u>			
				B. COUNTY <u>401</u>							
				C. CITY OR TOWN <u>Baltimore</u>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <u>8 E. Pleasant Street</u>							
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14, 1898</u>		9. AGE (in years last birthday) <u>72</u>		10. Under 1 Yr. Months Days	
				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Seaman</u>				11. BIRTHPLACE (State or foreign country) <u>Alabama</u>			
13. FATHER'S NAME <u>Alfonso Thiemonge</u>				14. MOTHER'S MAIDEN NAME <u>Margaret</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>438-03-4374</u>				17. INFORMANT <u>Mrs Winifred M. Thiemonge</u>			
								ADDRESS <u>8 E. Pleasant St.</u>			
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>As CVD - Decompensated</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>No</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>February 11</u> 19 <u>67</u> to <u>August 7</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>May 11</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (<u>did</u>) (did not) view the body after death.											
23A. SIGNATURE <u>Frank Supplac, III</u>				DEGREE Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>8/8/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>Frank Supplac, III</u>				DEGREE				23D. ADDRESS <u>1010 St Paul St, Balt 2, Md</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>8-10-1970</u>				24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>			
								24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Seabey, Jr.</u>				25C. FUNERAL DIRECTOR <u>Lilly & Zeiler Inc.</u>			
								ADDRESS <u>1901-07 Eastern Ave.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH/NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO.	
R-300 70 7917		70 7917		70 7917		70 7917	
1. NAME OF DECEASED (Type or Print) Joseph F. Roth Jr.				2. DATE AND HOUR OF DEATH 8/7/70			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL				A. STATE MARYLAND		B. COUNTY 102	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 137 S. ROBINSON STREET			
5. SEX Male	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-16-20	9. AGE (In years last birthday) 49	10. Under 1 Yr. Months	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY Parts Clerk		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME JOSEPH F. ROTH SR.				14. MOTHER'S MAIDEN NAME ELEANOR ALBERT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Joseph F. Roth III 137 S. Robinson St.	
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Cardiovascular (B) decause DUE TO, OR AS A CONSEQUENCE OF: (C) decause		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6/17 to 9/30 19 64 to 6/17 19 70 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 6/17 19 70 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> (did not) view the body after death.							
23A. SIGNATURE Luis Quintana MD				23B. DATE SIGNED 8/7/70			
23C. PHYSICIAN'S NAME (Type) Luis Quintana MD				23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-11-1970		24C. NAME OF CEMETERY OR CREMATORY Sacred Heart		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.			



FUNERAL DIRECTOR: IMPORTANT

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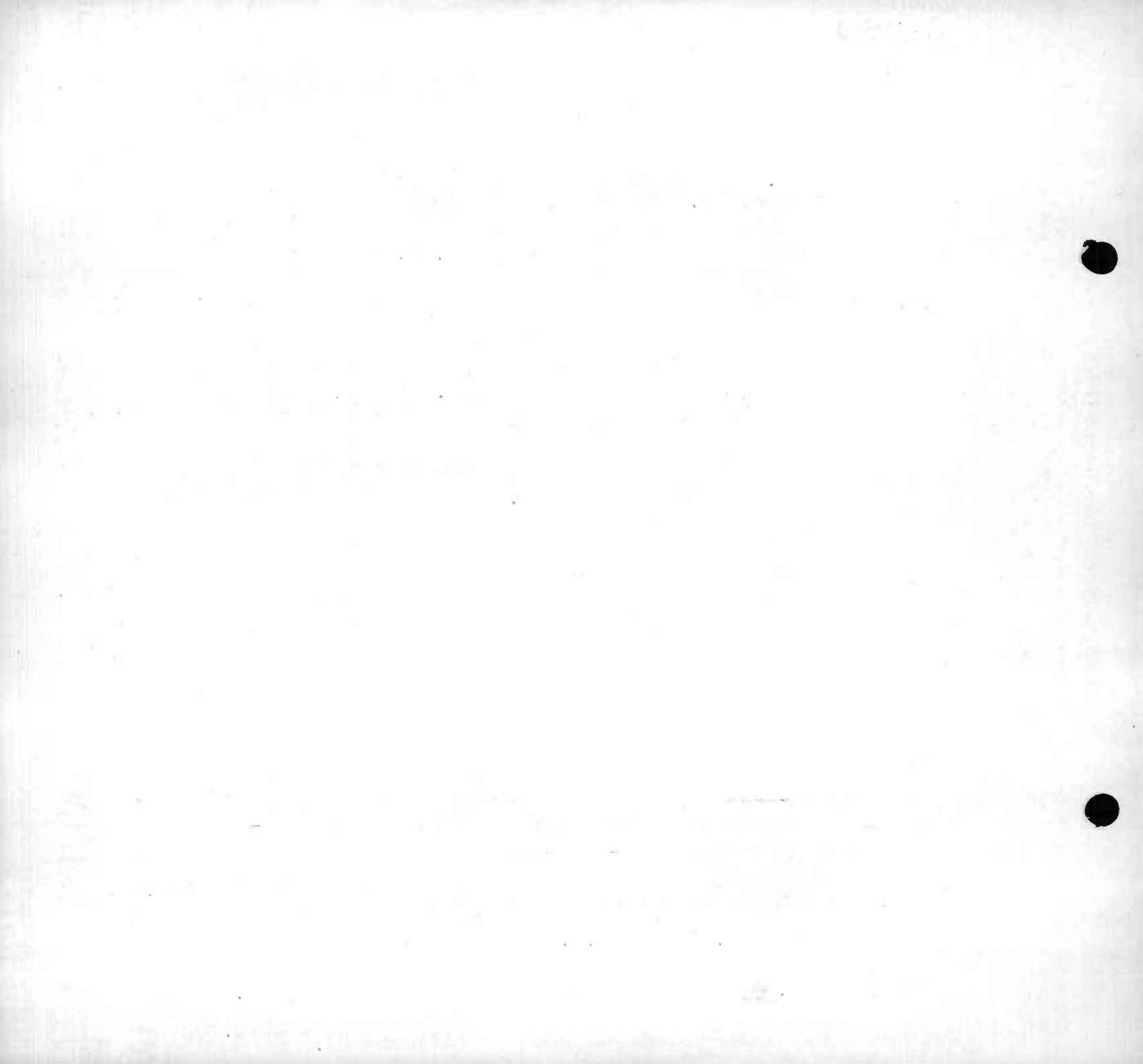
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7918	
BIRTH NO. 70 7918				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) RHODES A. WICKHAM			2. DATE AND HOUR OF DEATH 8 Aug 70 1 8 AM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2608 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 304 S CONKLING ST. 21224		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Jun 1904	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cooper		10B. KIND OF BUSINESS OR INDUSTRY Kinble-Tyler	11. BIRTHPLACE (State or foreign country) Md. Frederick		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ROBERT F			14. MOTHER'S MAIDEN NAME Annie		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 11-5-42 3-22-43		16. SOCIAL SECURITY NO. 213-01-5735A	17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Undifferentiated Cancer involving liver & probably from lung (metastases). ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? 2 months		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 22 Jul 1970 to 8 Aug 1970 that (I) (we) last saw the deceased alive on 8 Aug 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edmund Beacham M.D.			23B. DATE SIGNED 9 Aug 70		
23C. PHYSICIAN'S NAME (Type) Edmund Beacham M.D.			23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Maryland 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-12-1970	24C. NAME of CEMETERY or CREMATORY Baltimore National	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970	25B. NAME OF REGISTRAR Robert E. Tabor	25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

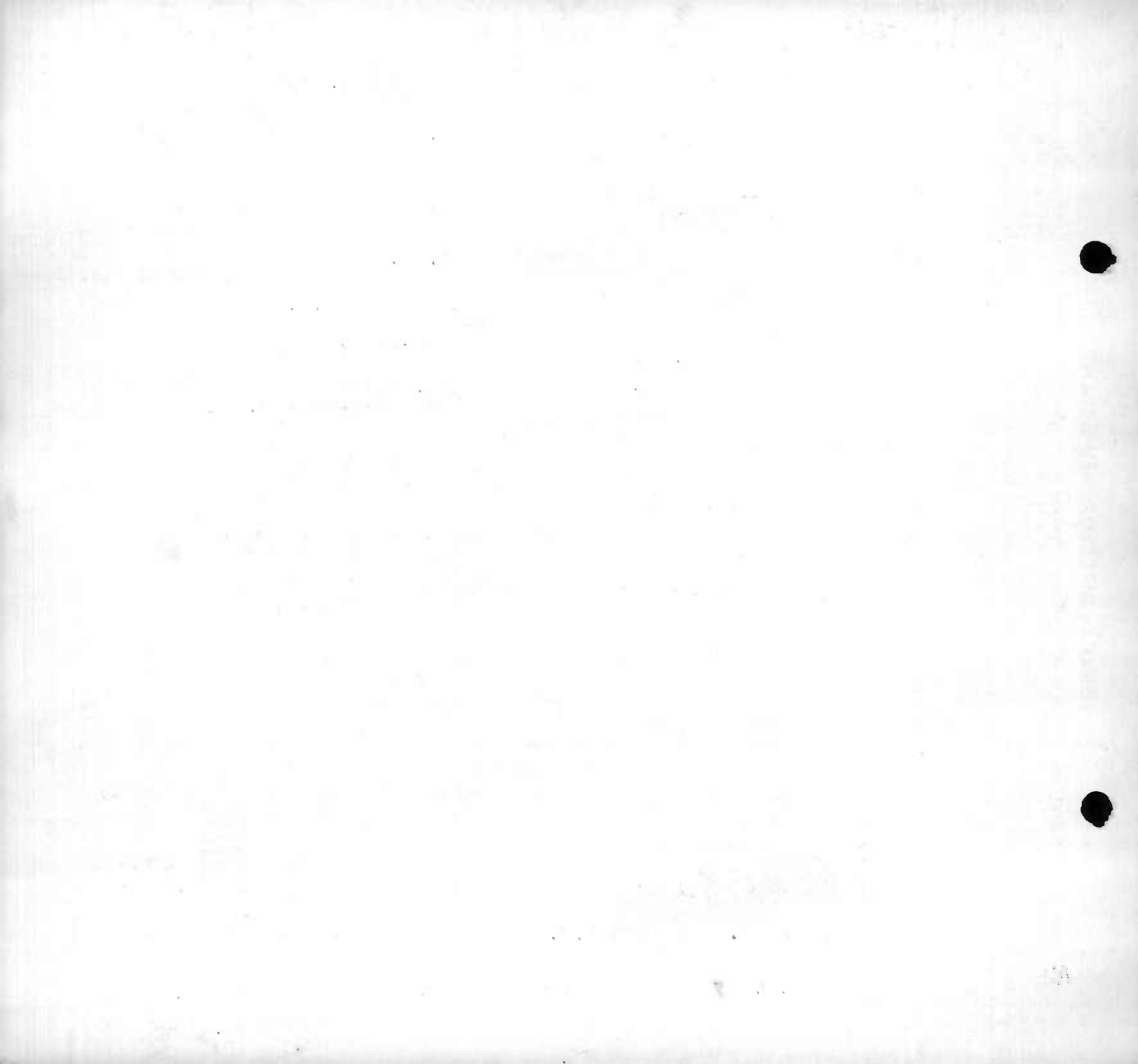
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7919	
1. NAME OF DECEASED (Type or Print) <div style="text-align: center; font-size: 1.2em;">Enola Louise Dawson</div>		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> August 6, 1970 4 A.M. M. </div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 1.2em;">00 3039 Barclay Street Baltimore, Md. 21218</div>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1202 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <div style="font-size: 1.2em;">3039 Barclay Street</div>			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28. 1877	9. AGE (In years lost birthday) 92	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel Bullen		14. MOTHER'S MAIDEN NAME Susie ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Alice P. Wilkerson 3039 Barclay St. Baltimore Md. 21218	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 45%;"> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <div style="font-size: 1.2em;">Arteriosclerotic cardiovascular disease</div> </div> <div style="width: 10%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <div style="font-size: 1.2em;">15 yrs</div> </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 19 64 to August 6, 19 70, that (I) last saw the deceased alive on July 31, 19 70 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <div style="font-size: 1.5em;">Lloyd E. Saylor M.D.</div>				23B. DATE SIGNED Aug. 6, 1970	
23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor M.D.				23D. ADDRESS 3902 Greenmount Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 9, 1970		24C. NAME OF CEMETERY or CREMATORY Mayo Cemetery	
24D. LOCATION (City, town, or county) (State) Mayo, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. Baltimore Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 7920
B-600 70 7920 BIRTH NO.		1. NAME OF DECEASED (Type or Print) Claudia Blair Barry		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 House in the Pines (Belvedere)		2. DATE AND HOUR OF DEATH Aug. 5, 1970 750K M. 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 809 Lake Drive		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1885 9. AGE (In years last birthday) 81 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D.C.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Harrison		
14. MOTHER'S MAIDEN NAME Jessie Fraysier		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Elizabeth Knapp (sister) 3702 Bayonne Ave. Baltimore 21206		
18. 410.0 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute M.I. Myocardial infarction (B) Chronic Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF: A (C)				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 10 hrs 104				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 7/21/70 19 to 8/5/70 19, that (I) (we) last saw the deceased alive on 7/24/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Lester N. Kolman M.D.		23B. DATE SIGNED 8/6/70		23C. PHYSICIAN'S NAME (Type) Lester N. Kolman M.D.
23D. ADDRESS 6821 Reisterstown Road		24A. BURIAL CREMATION, REMOVAL (Specify) Burial Aug. 8, 1970		
24B. NAME OF CEMETERY or CREMATORY Glen Haven Park Cem.		24C. LOCATION (City, town, or county) (State) Baltimore Md.		
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Barber, M.D.		25C. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC Baltimore Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 7921	
C-245 70 7921 BIRTH NO. 1. NAME OF DECEASED (Type or Print) MAYC CHISHOLM		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> Aug. 6. 1970 7.45 P. M. </div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3101 Normount Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 101 C. CITY OR TOWN Baltimore 21224 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3002 Hudson Street			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1. 1884		9. AGE (In years last birthday) 85
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Thomas			14. MOTHER'S MAIDEN NAME Lizza Jane Stuart		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-10-3081		17. INFORMANT Roland Ruhwadel 3101 Normount Ave. Baltimore Md	
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. </div> <div style="width: 45%;"> CAUSE OF DEATH A. S. C. U. D. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-1-1970 to 7-7-1970, that (I) (we) last saw the deceased alive on 7-18-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Barbu Calin M.D. <small>DEGREE</small>				23B. DATE SIGNED Aug. 8-1970	
23C. PHYSICIAN'S NAME (Type) BARBU CALIN, M.D. <small>DEGREE</small>				23D. ADDRESS 831 Poplar Grove St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 10. 1970		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970			
25B. NAME OF REGISTRAR Robert E. Barber, M.D.		25C. FUNERAL DIRECTOR HENRY SANDER & SONS. INC Baltimore Md.			

Normanville

George Thomas

no

213-10-3081

Normanville

Lizs Jane Stuart

Roland Ruhwadel
3101 Normount Ave. Baltimore Md
21216

USA

FUNERAL DIRECTOR: IMPORTANT

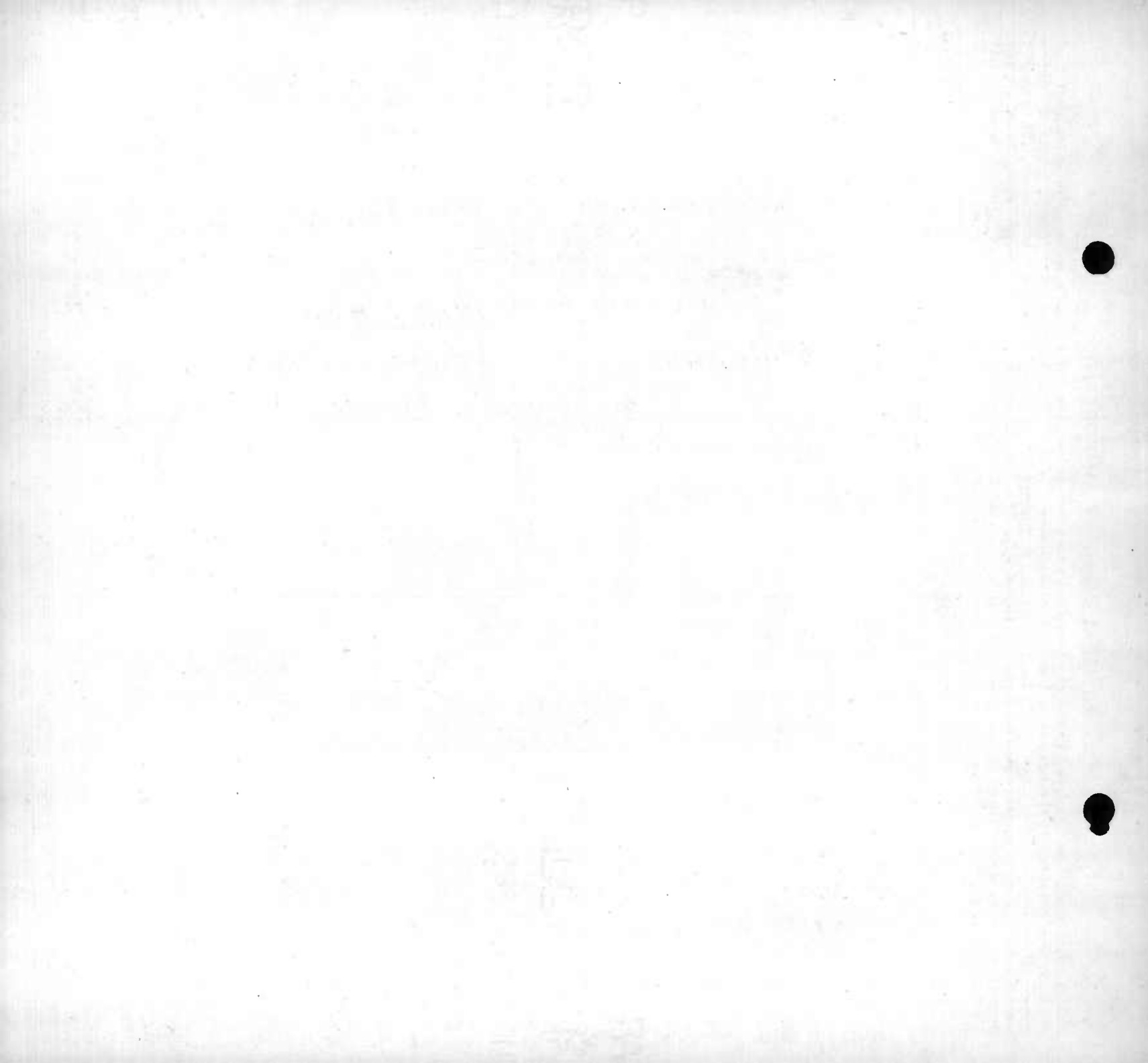
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>70 7922</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 7922</u>	
1. NAME OF DECEASED (Type or Print) <u>ERNESTINE ATKINS</u>				2. DATE AND HOUR OF DEATH <u>7/29/70</u> <u>1100</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY HOSP.</u>				A. STATE <u>MD.</u>		B. COUNTY <u>1501</u>	
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1385 GILMORE ST</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/27/28</u>	9. AGE (in years last birthday) <u>41</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>LOUIS DORSEY</u>				14. MOTHER'S MAIDEN NAME <u>LENA JOHNSON</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Elenora Galloway 1121 McKean St</u>	
18. <u>442A</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>RESPIRATORY ARREST</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ANEURYSM OF INT. CAROTID</u>				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7/29</u> 19 <u>70</u> to <u>7/27</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>7/27</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Daniel M. Cook</u>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS				23E. ADDRESS		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>8/3/70</u>		<u>8/3/70</u>		<u>MT. ARBURN CEM.</u>		<u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
<u>AUG 10 1970</u>		<u>Robert E. Fisher, M.D.</u>		<u>G.B. Johnson</u>		<u>19006</u>	

FUNERAL DIRECTOR: IMPORTANT

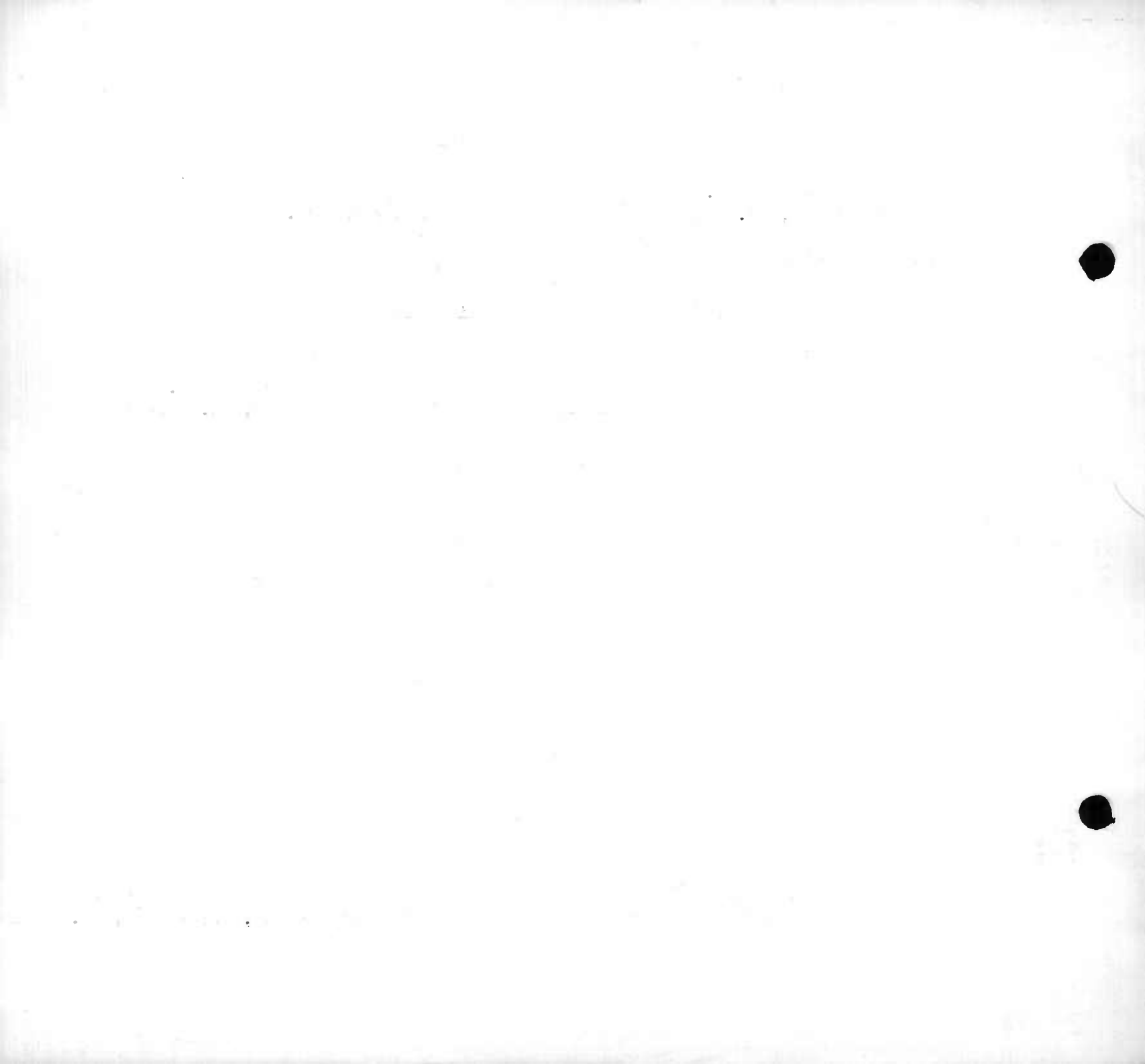
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 7923
M-250 70 7923 CERTIFICATE OF DEATH				REG. NO. 70 7923
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GEORGE MACGOWAN		2. DATE AND HOUR OF DEATH JULY 22, 1970 8:00 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2716		
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2518 EDMONDE CIR., NORTH		
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-21-32	9. AGE (In years last birthday) 38
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY SOC. SEC. ADMIN.		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George M. Gowan		
14. MOTHER'S MAIDEN NAME Louise Clemons		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes		
16. SOCIAL SECURITY NO. 215-28-4534		17. INFORMANT Gertrude M. Cowan (Same)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 577.0		CAUSE OF DEATH (A) IMMEDIATE CAUSE ACUTE HEMORRHAGIC PANCREATITIS DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that we (this hospital) attended the deceased from JULY 20, 1970 to JULY 22, 1970 , that we (we) last saw the deceased alive on JULY 22, 1970 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) (did not) view the body after death.				
23A. SIGNATURE Christos Dibranos, M.D.		23B. DATE SIGNED JULY 22, 70		23C. PHYSICIAN'S NAME (Type) CHRISTOS DIBRANOS, M.D.
23D. ADDRESS 730 ASHBURTON STR., BALTO., MD. 21216		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 7/25/70		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park Baltimore		24D. LOCATION (City, town, or county) (State) Md
25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR Robert E. Fisher, Jr.		25C. FUNERAL DIRECTOR J. B. Johnson
25D. ADDRESS Balt, Md				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Y-430		70 7924		BALTIMORE CITY HEALTH DEPARTMENT		70 7924	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>Ernest Valt</u>				2. DATE AND HOUR OF DEATH <u>8/7/70</u> <u>3:20 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>31 4940 Eastern Ave.</u> <u>Baltimore, Md. 21224</u>				A. STATE <u>Maryland</u> B. COUNTY <u>2608</u>			
C. CITY OR TOWN <u>Baltimore</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>3404 Leverton Ave. 21224</u>							
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-7-02</u>	9. AGE (In years lost birthday) <u>68</u>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 1 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Candido</u>				14. MOTHER'S MAIDEN NAME <u>Maria</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-4093</u>		17. INFORMANT BCH Records: <u>4940 Eastern Ave.</u> <u>Baltimore, Md. 21224</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Gastrointestinal Bleeding</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Peptic Ulcer Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic Obstructive Pulmonary Disease</u> (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 months</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>8/7/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8/7</u> 19 <u>70</u> to <u>8/7</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>8/7</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Harold S. Goldberg</u>				23B. DATE SIGNED <u>8/7/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Harold S. Goldberg</u>	
23D. ADDRESS <u>Baltimore City Hospitals</u>				23E. ADDRESS <u>4940 Eastern Ave. Baltimore, Md. 21224</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <u>8/10/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mary Redeemer</u>		24D. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Joseph H. Zimmerman</u>		25D. ADDRESS <u>5. Con King</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-4601

70 7925

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 70 7925

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ALMA E. TYLER <i>ALMA TYLER D. AKA Alma Janet Tyler</i>		2. DATE AND HOUR OF DEATH 4:25 AM 8/6/70	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Anne Arundle		5. CITY OR TOWN Annapolis D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital		E. STREET AND NUMBER 304 Annapolis Street			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/5/12	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher		10B. KIND OF BUSINESS OR INDUSTRY public school		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Erickson		14. MOTHER'S MAIDEN NAME Gerda Anderson Gustavson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service no		16. SOCIAL SECURITY NO. 212-28-0609		17. INFORMANT George A. Erickson ADDRESS 830 Bay Ridge Ave., Annapolis, Md.	
18. 796.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) Acute Renal Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Recurrent Capillary of Stomach		(B) 3 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Postop Rotation Flap For Radiation Ulcer					
19A. DATE OF OPERATION 37/31/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Radiation Ulcer		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 7/30 19 72 to 8/6 19 70 that (b) (we) last saw the deceased alive on 8/6 19 70 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Carl Bradenburg</i>		23B. DATE SIGNED 8/6/70			
23C. PHYSICIAN'S NAME (Type) Carl Bradenburg, M.D.		23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/9/70		24C. NAME of CEMETERY or CREMATORY Cedar Bluff Cemetery	
24D. LOCATION Annapolis A.A. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970		25B. NAME OF REGISTRAR 23.8 E. Faber, Md.	
25C. FUNERAL DIRECTOR Beverly E. Hopping		25D. ADDRESS HOPPING FUNERAL HOME - Annapolis, Md.			

20Y

B-2201

70 7926 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

70 7926

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHN F. BISASKY

2. DATE AND HOUR OF DEATH

August 8, 1970

9:05 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 629 S. Fagley Street

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

629 S. Fagley Street

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

Sept. 5, 1910

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cab Driver

10B. KIND OF BUSINESS OR INDUSTRY

Sun Cab

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Bisasky

14. MOTHER'S MAIDEN NAME

Helen Slezak

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Rose L. Swegon 629 S. Fagley Street

18. 1621 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Generalized Metastasis

(B) CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Ca - Lung

(C) Paralysis - R. side

March 1970

April 1970

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐ Not While
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/6 1970 to 8/8 1970.
that (I) (we) last saw the deceased alive on 8/7 1970 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Louis F. Klimes M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

8/10/70

23C. PHYSICIAN'S
NAME (Type)

LOUIS F. KLIMES M.D.

23D. ADDRESS

2623 S. Monument St. Baltimore, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8-12-1970

24C. NAME OF CEMETERY OR CREMATORY

Sacred Heart

24D. LOCATION

Baltimore County, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 10 1970

25B. NAME OF REGISTRAR

Robert E. Slezak M.D.

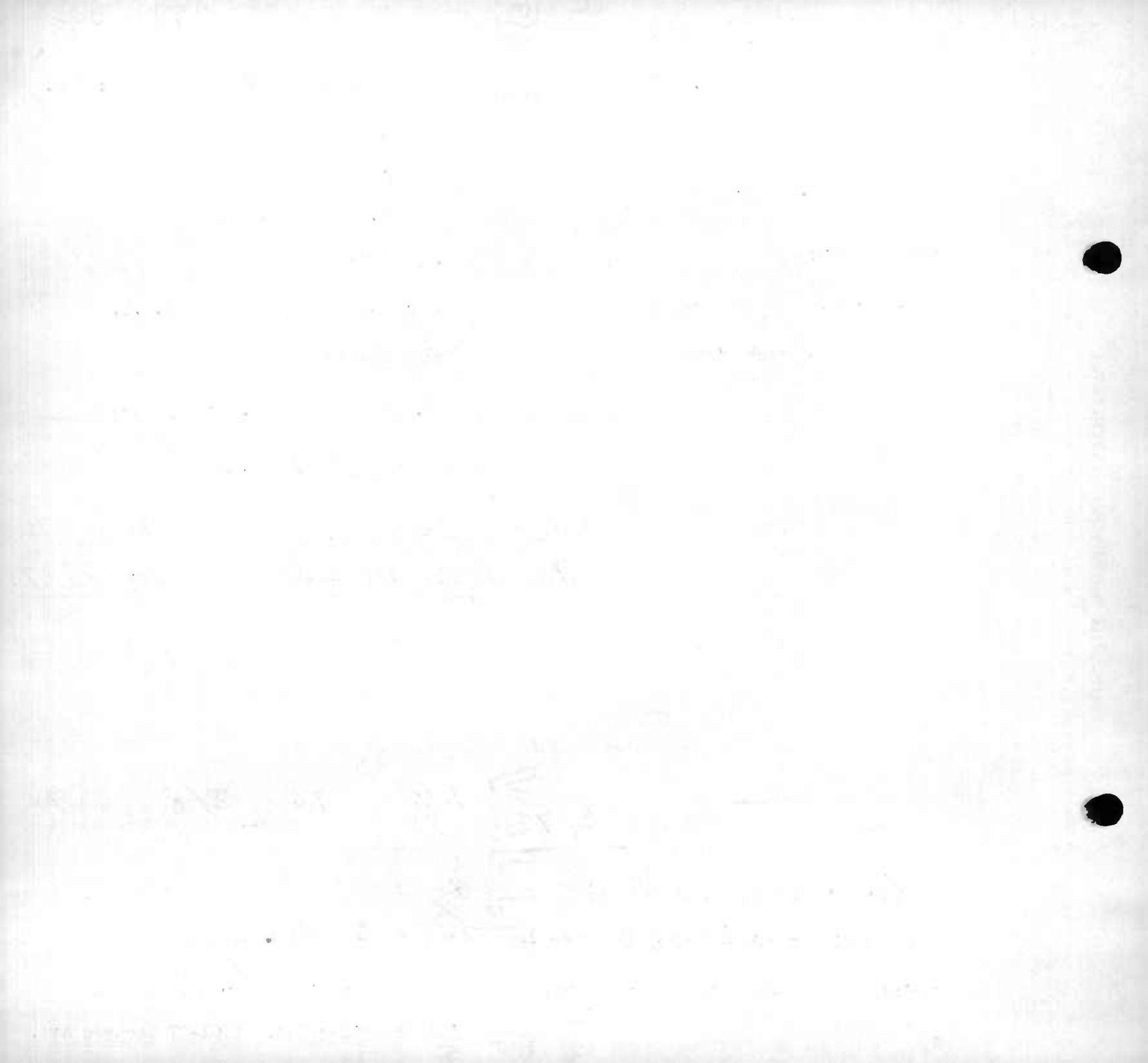
25C. FUNERAL DIRECTOR

Lilly & Zeiler Inc. 1901-07 Eastern Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

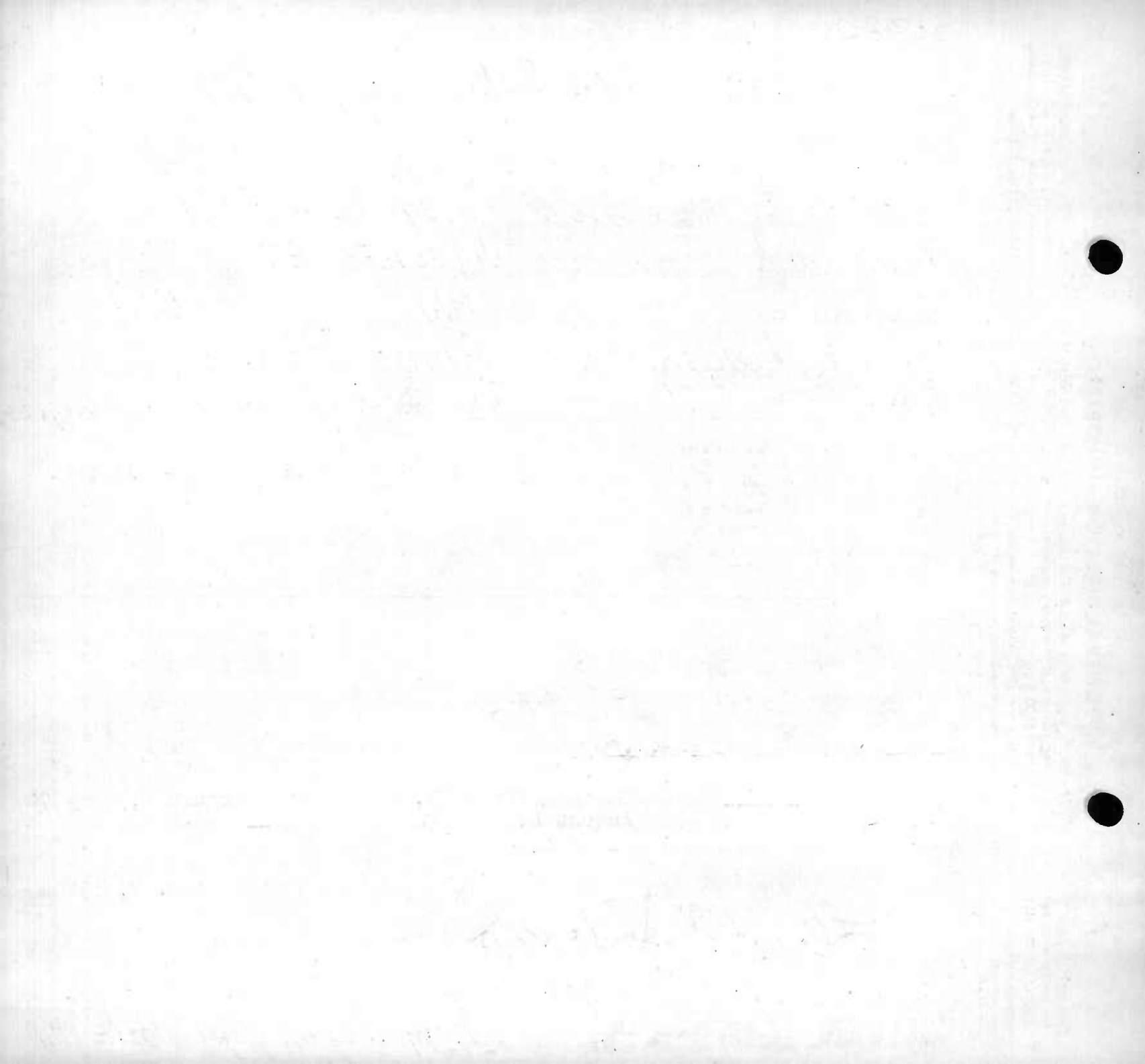
BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <i>Yellott</i> ELEANOR RIDGELY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> _____ M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>117 Park Avenue</i>		3. DATE PRONOUNCED DEAD Month Day Year <i>August 4, 1970</i> Hour <i>11:25</i> P. M.	
6. SEX <i>Female</i>		7. RACE <i>White</i>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <i>Baltimore</i>	
9. DATE OF BIRTH <i>February 17, 1914</i>		10. AGE (In years last birthday) <i>56</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Richard Emory Yellott</i>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1102</i>	
15. MOTHER'S MAIDEN NAME <i>Mary Carter</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>	
17. SOCIAL SECURITY NO. <i>062-28-2441</i>		18. INFORMANT ADDRESS <i>Family records</i>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Overdose of barbiturates</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
20A. DATE OF OPERATION <i>8-4-70</i>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
21. AUTOPSY? (Yes or No) <i>no</i>		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>home</i>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>717 Park Avenue 1102</i>	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <i>8-4-70 11:15 P. M.</i>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <i>Ingested overdose of barbiturates.</i>		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <i>Ronald N. Kornblum, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>8/5/70</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Aug. 7, 1970</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Trinity Episcopal Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Long Green, Balto Co., Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 10 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fabel, M.D.</i>	
25C. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Md.</i>		ADDRESS _____	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

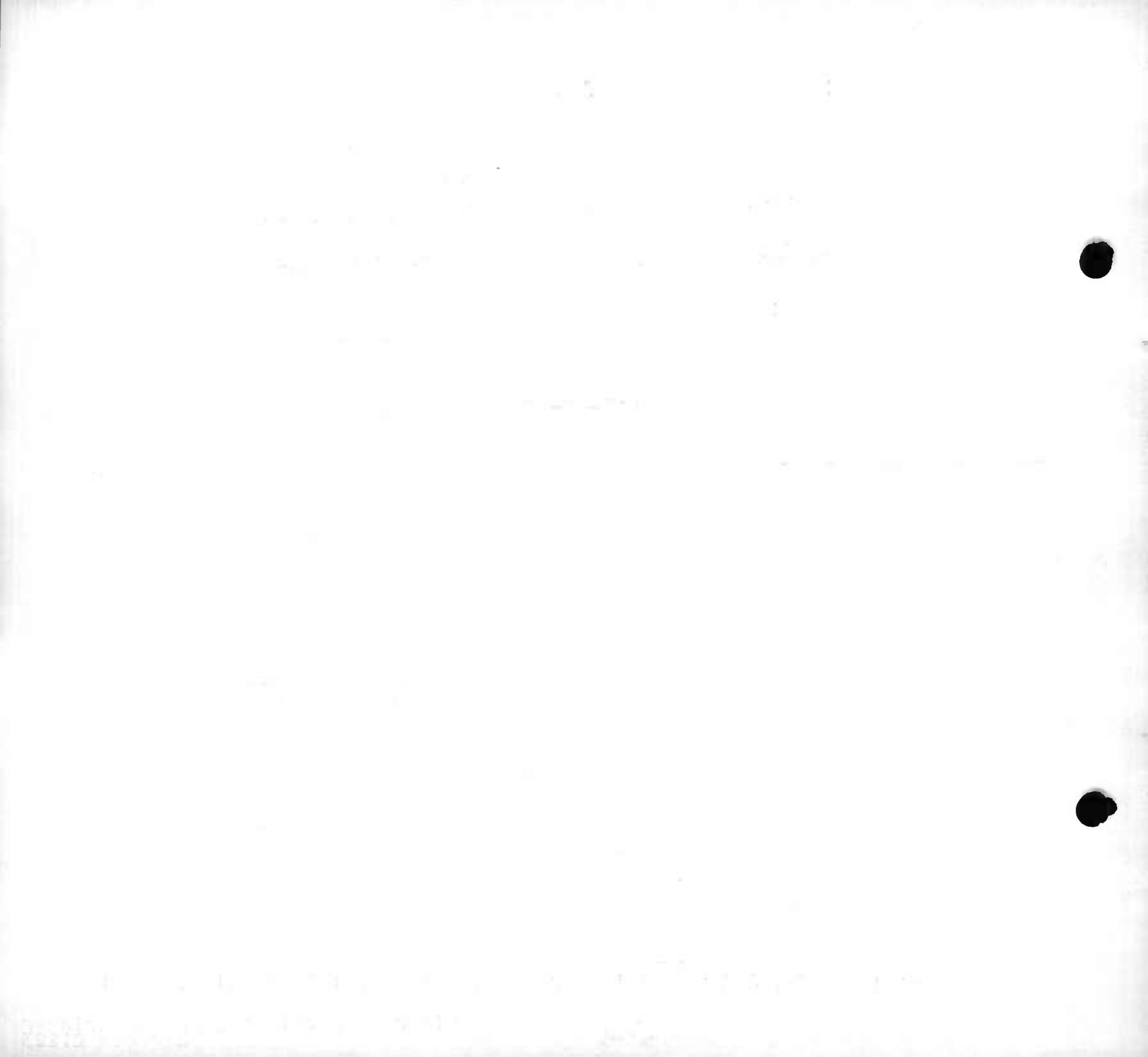
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7928</u>
S-220 <u>70 7928</u>		CERTIFICATE OF DEATH		
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>SARAH ELLEN SYKES</u>		Aug 6 1970 10:15 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Ardeleigh Nursing Home</u> <u>90 2095 Rockrose Ave</u>		A. STATE <u>Md</u>		B. COUNTY <u>1348</u>
		C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>Jul 30 1883</u>		9. AGE (In years last birthday) <u>87</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George Lindsay</u>		
14. MOTHER'S MAIDEN NAME <u>Annie Rodgers</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Donald R Decker</u> ADDRESS <u>1305 Asbury Ave</u>		
18. <u>412.4</u>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic cardiovascular disease</u> <u>15 yrs.</u>		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>June 13, 1962</u> to <u>August 6, 1970</u> , that (I) (we) last saw the deceased alive on <u>August 4, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Joseph E. Saylor MD</u>				23B. DATE SIGNED <u>Aug. 7, 1970</u>
23C. PHYSICIAN'S NAME (Type) <u>Joseph E. Saylor MD</u>				23D. ADDRESS <u>2902 Greenmount Avenue</u>
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Aug 10 70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St Mary's (Hampden)</u>
24D. LOCATION (City, town, or county) <u>Balto Md</u>		24E. FUNERAL DIRECTOR <u>Burgess Funeral Home</u> ADDRESS <u>Balto Md</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher MD</u>		

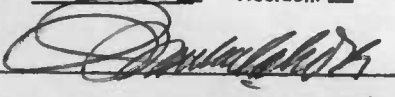


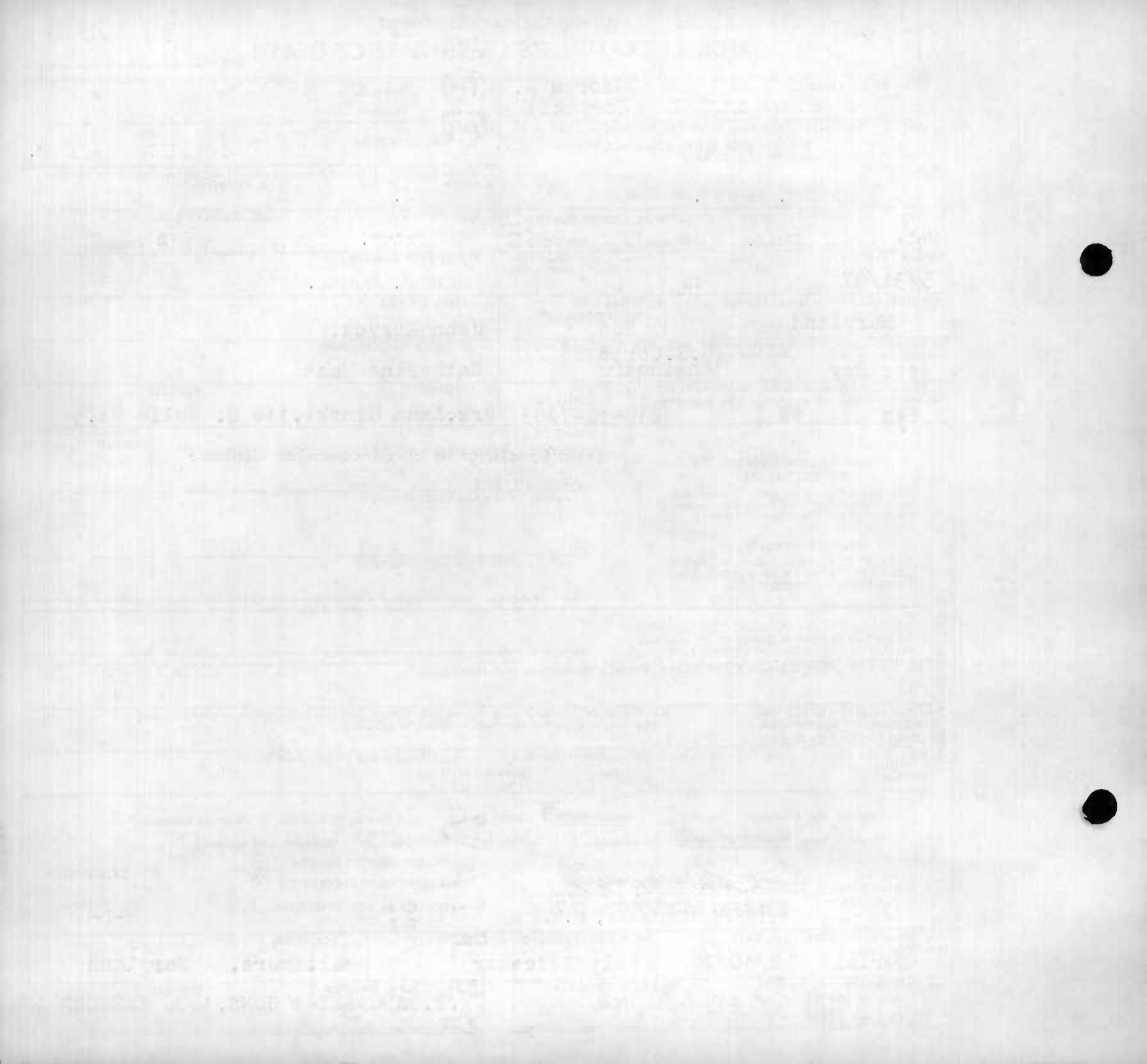
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-365 70 7929				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 7929	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Widderman Ruth, N.</i>				2. DATE AND HOUR OF DEATH <i>8/4/70 5:50 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Bon Secours Hosp.</i>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Balto.</i> C. CITY OR TOWN <i>Balto.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>309 S. Park St 21223</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>07/06/92</i>	9. AGE (in years last birthday) <i>78</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>George M. Carson</i>			
14. MOTHER'S MAIDEN NAME <i>Lillian M. Carson</i>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No.</i>			
16. SOCIAL SECURITY NO. <i>217-40-0244</i>				17. INFORMANT <i>B. Behm RN</i> ADDRESS <i>Bon Secours</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>250.01 Metabolic acidosis</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Diabetes mellitus</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Postnecrotic cirrhosis</i>				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>?</i>		(C) DUE TO, OR AS A CONSEQUENCE OF: <i>?</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in at about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from <i>Aug. 4</i> 19 <i>70</i> to <i>Aug. 4</i> 19 <i>70</i> and that (I) was last saw the deceased alive on <i>Aug. 4</i> 19 <i>70</i> and that (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.							
23A. SIGNATURE <i>L. Lafranco M.D.</i> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8-4-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>Lilia Lafranco M.D.</i> DEGREE				23D. ADDRESS <i>Bon Secours Hosp. 2025 W. Fayette St.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>08/07/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore City, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 10 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>		25C. FUNERAL DIRECTOR <i>Walters Funeral Home</i>		ADDRESS <i>Pratt & Stricker Streets 21223</i>	



70 7930		BALTIMORE CITY HEALTH DEPARTMENT		70 7930	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) George A. KORYSKI (Korycki)				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 212 S. Ann St.				3. DATE PRONOUNCED DEAD Month Day Year Hour 8 6 1970 4:55 P.M.	
6. SEX Male				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 202	
7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 5/31/97		10. AGE (In years last birthday) 73		E. STREET AND NUMBER 212 S. Ann St.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Korycki	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mess Boy		14B. KIND OF BUSINESS OR INDUSTRY U.S. Corps of Engineers		15. MOTHER'S MAIDEN NAME Katherine Mach	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I		17. SOCIAL SECURITY NO. 216-12-7363		18. INFORMANT ADDRESS Mrs. Anna Ginski, 114 S. Wolfe St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) no
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE  M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8-7-70 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/10/70		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS M.F. SADOWSKI & SONS, 1808 EASTERN AVE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-530 70 7931		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 7931	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARILYN AHMUTY			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH August 5, 1970 7:25 P.M.			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY of Maryland Hospital 38		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN PASADENA D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 520 E. STREET AND NUMBER Box 338 A Arcadia Rd Rt 9			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 24, 1955	9. AGE (in years last birthday) 14	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert AHMUTY			
14. MOTHER'S MAIDEN NAME Catherine League		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. mmmm		17. INFORMANT Hospital Record			
18. 194.01		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Adrenal CARCINOMA			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 30 19 70 to August 5 19 70 that (I) (we) last saw the deceased alive on Aug 5 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alfonso H Janoski, MD		23B. DATE SIGNED Aug 5, 1970		23C. PHYSICIAN'S NAME (Type) ALFONSO H JANOSKI, MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/8/70		24C. NAME of CEMETERY or CREMATORY Epiphany Episc. Ch. Cem.	
24D. LOCATION (City, town, or county) (State) Odenton, Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 10 1970			
25B. NAME OF REGISTRAR Robert E. Jaber, MD		25C. FUNERAL DIRECTOR R-V Singleton			
25D. ADDRESS Singleton Funeral Home		25E. ADDRESS Odenton, Md.			

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Food 2

Food 2

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                      |         |                                                                                          |                  | X                                                                                     |                                 | REG. NO. 70 7932                                                     |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------|---------------------------------|----------------------------------------------------------------------|--|
| P-536 70 7932                                                                                                                                                                                                                                                                                                         |         |                                                                                          |                  | BIRTH NO.                                                                             |                                 |                                                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                |         |                                                                                          |                  | 2. DATE AND HOUR OF DEATH                                                             |                                 |                                                                      |  |
| PONTIER, WILLIAM LEWIS                                                                                                                                                                                                                                                                                                |         |                                                                                          |                  | AUGUST 4, 1970                                                                        |                                 | 3:30 PM.                                                             |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                |         |                                                                                          |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |                                 |                                                                      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br>40 ST AGNES HOSPITAL                                                                                                                                                                              |         |                                                                                          |                  | A. STATE                                                                              |                                 | B. COUNTY                                                            |  |
|                                                                                                                                                                                                                                                                                                                       |         |                                                                                          |                  | MARYLAND                                                                              |                                 | ANNE ARUNDEL 5200                                                    |  |
|                                                                                                                                                                                                                                                                                                                       |         |                                                                                          |                  | C. CITY OR TOWN                                                                       |                                 | D. INSIDE CITY LIMITS?                                               |  |
|                                                                                                                                                                                                                                                                                                                       |         |                                                                                          |                  | HANOVER                                                                               |                                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
|                                                                                                                                                                                                                                                                                                                       |         |                                                                                          |                  | E. STREET AND NUMBER                                                                  |                                 |                                                                      |  |
|                                                                                                                                                                                                                                                                                                                       |         |                                                                                          |                  | 7401 MULBERRY ROAD                                                                    |                                 |                                                                      |  |
| 5. SEX                                                                                                                                                                                                                                                                                                                | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    | 8. DATE OF BIRTH |                                                                                       | 9. AGE (In years lost birthday) | II Under 1 Yr. Months Days II Under 24 Hrs. Hours Min.               |  |
| MALE                                                                                                                                                                                                                                                                                                                  | WHITE   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | 12 25 02         |                                                                                       | 67                              |                                                                      |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                           |         |                                                                                          |                  | 10B. KIND OF BUSINESS OR INDUSTRY                                                     |                                 | 11. BIRTHPLACE (State or foreign country)                            |  |
| SALESMAN                                                                                                                                                                                                                                                                                                              |         |                                                                                          |                  | Balto. Sight Seeing Tours                                                             |                                 | MARYLAND                                                             |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                     |         |                                                                                          |                  | 12. CITIZEN OF WHAT COUNTRY?                                                          |                                 |                                                                      |  |
| Unknown                                                                                                                                                                                                                                                                                                               |         |                                                                                          |                  | U S A                                                                                 |                                 |                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                              |         |                                                                                          |                  | 16. SOCIAL SECURITY NO.                                                               |                                 | 17. INFORMANT ADDRESS                                                |  |
| NO None                                                                                                                                                                                                                                                                                                               |         |                                                                                          |                  | 213-05-9156                                                                           |                                 | ST AGNES RECORDS-BALTO MD 21229                                      |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                    |         |                                                                                          |                  | CAUSE OF DEATH                                                                        |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                          |         |                                                                                          |                  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                   |                                 |                                                                      |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                     |         |                                                                                          |                  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                   |                                 |                                                                      |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                             |         |                                                                                          |                  | (C) A SEUD                                                                            |                                 |                                                                      |  |
| II                                                                                                                                                                                                                                                                                                                    |         |                                                                                          |                  |                                                                                       |                                 |                                                                      |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                      |         |                                                                                          |                  | GI Bleeding 20 to Congestion                                                          |                                 |                                                                      |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |                  | 20A. AUTOPSY? (Yes or No)                                                             |                                 | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 2, none                                                                                                                                                                                                                                                                                                               |         |                                                                                          |                  | Yes                                                                                   |                                 |                                                                      |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                 |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                                 |                                                                      |  |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                         |         | 21E. INJURY OCCURRED                                                                     |                  | 21F. HOW DID INJURY OCCUR?                                                            |                                 |                                                                      |  |
|                                                                                                                                                                                                                                                                                                                       |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                  |                                                                                       |                                 |                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from JULY 29 19 70 to AUGUST 4 1970 that (I) (we) last saw the deceased alive on AUGUST 4, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |                                                                                          |                  |                                                                                       |                                 |                                                                      |  |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                        |         |                                                                                          |                  | 23B. DATE SIGNED                                                                      |                                 |                                                                      |  |
| G. Patrick M.D.                                                                                                                                                                                                                                                                                                       |         |                                                                                          |                  | 08 04 70                                                                              |                                 |                                                                      |  |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                          |         |                                                                                          |                  | 23D. ADDRESS                                                                          |                                 |                                                                      |  |
| G PATRICK M.D.                                                                                                                                                                                                                                                                                                        |         |                                                                                          |                  | ST AGNES HOSP BALTO MD 21229                                                          |                                 |                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                              |         | 24B. DATE                                                                                |                  | 24C. NAME OF CEMETERY or CREMATORY                                                    |                                 | 24D. LOCATION (City, town, or county) (State)                        |  |
| Burial                                                                                                                                                                                                                                                                                                                |         | 8/8/70                                                                                   |                  | Lorraine Park Cemetery                                                                |                                 | Baltimore, Md.                                                       |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                       |         | 25B. NAME OF REGISTRAR                                                                   |                  | 25C. FUNERAL DIRECTOR                                                                 |                                 | ADDRESS                                                              |  |
| AUG 10 1970                                                                                                                                                                                                                                                                                                           |         | Robert E. Farber, M.D.                                                                   |                  | Singleton Funeral Home                                                                |                                 | Glen Burnie, Md.                                                     |  |

EXHIBIT 10-10

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EXHIBIT 10-10

EXHIBIT 10-10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 5-550 70 7933                                                                                                                                                                                 |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                              |  | X REG. NO. 70 7933                                                                                       |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                     |  | 1. NAME OF DECEASED<br>(Type or Print) <b>SEMAN, Paul Charles</b>                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br><b>Aug. 6, 1970 12 20 A.M.</b>                                              |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                        |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                                                                                         |  | 5. STATE                                                                                                 |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>South Baltimore General Hospital</b>                                                                                                               |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                          |  | C. CITY OR TOWN<br><b>Glen Burnie</b>                                                                    |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Student</b>                                                                                 |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>School</b>                                                                                                                                                                            |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>520</b> |  |
| 13. FATHER'S NAME<br><b>Paul Charles Seman, Sr.</b>                                                                                                                                           |  | 14. MOTHER'S MAIDEN NAME<br><b>Dolores Knott</b>                                                                                                                                                                              |  | E. STREET AND NUMBER<br><b>938 Genie Court 21061</b>                                                     |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                         |  | 16. SOCIAL SECURITY NO.<br><b>None</b>                                                                                                                                                                                        |  | 17. INFORMANT<br><b>Mr. Paul C. Seman, Sr. - the chart</b>                                               |  |
| 18. <b>23811</b>                                                                                                                                                                              |  | CAUSE OF DEATH                                                                                                                                                                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                             |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Brain tumor</b>                                                                                                                                                  |  | <b>1 1/2 yrs</b>                                                                                         |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                           |  |                                                                                                          |  |
| (C) _____                                                                                                                                                                                     |  |                                                                                                                                                                                                                               |  |                                                                                                          |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>LLC pneumonia</b>                                |  |                                                                                                                                                                                                                               |  |                                                                                                          |  |
| 19A. DATE OF OPERATION                                                                                                                                                                        |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                              |  | 20A. AUTOPSY? (Yes or No)                                                                                |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                         |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                      |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                 |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                     |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                        |  | 21F. HOW DID INJURY OCCUR?                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>8/4</b> 19 <b>70</b> to <b>8/6</b> 19 <b>70</b>                                                                          |  | that (I) (we) last saw the deceased alive on <b>8/6</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                          |  |
| 23A. SIGNATURE<br><b>Sang Y. Rhim M.D.</b>                                                                                                                                                    |  | 23B. DATE SIGNED<br><b>8/6/70</b>                                                                                                                                                                                             |  | 23C. PHYSICIAN'S NAME (Type)<br><b>SANG Y. RHIM</b>                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                      |  | 24B. DATE<br><b>Aug. 10, 1970</b>                                                                                                                                                                                             |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>                                        |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>AUG 10 1970</b>                                                                                                                                         |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Sabers</b>                                                                                                                                                                             |  | 25C. FUNERAL DIRECTOR<br><b>R. Singleton</b>                                                             |  |
| 25D. LOCATION (City, town, or county) (State)<br><b>Glen Burnie, Md.</b>                                                                                                                      |  | 25E. ADDRESS<br><b>938 Genie Court, Glen Burnie, Md.</b>                                                                                                                                                                      |  |                                                                                                          |  |

James Harrison (Cousin, May 1855)

Dear Sir

Thank you for the

enclosed note

Yours truly

Wm Harrison

133 St. Louis St.

St. Louis, Mo.

Very respectfully

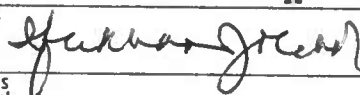
Wm Harrison

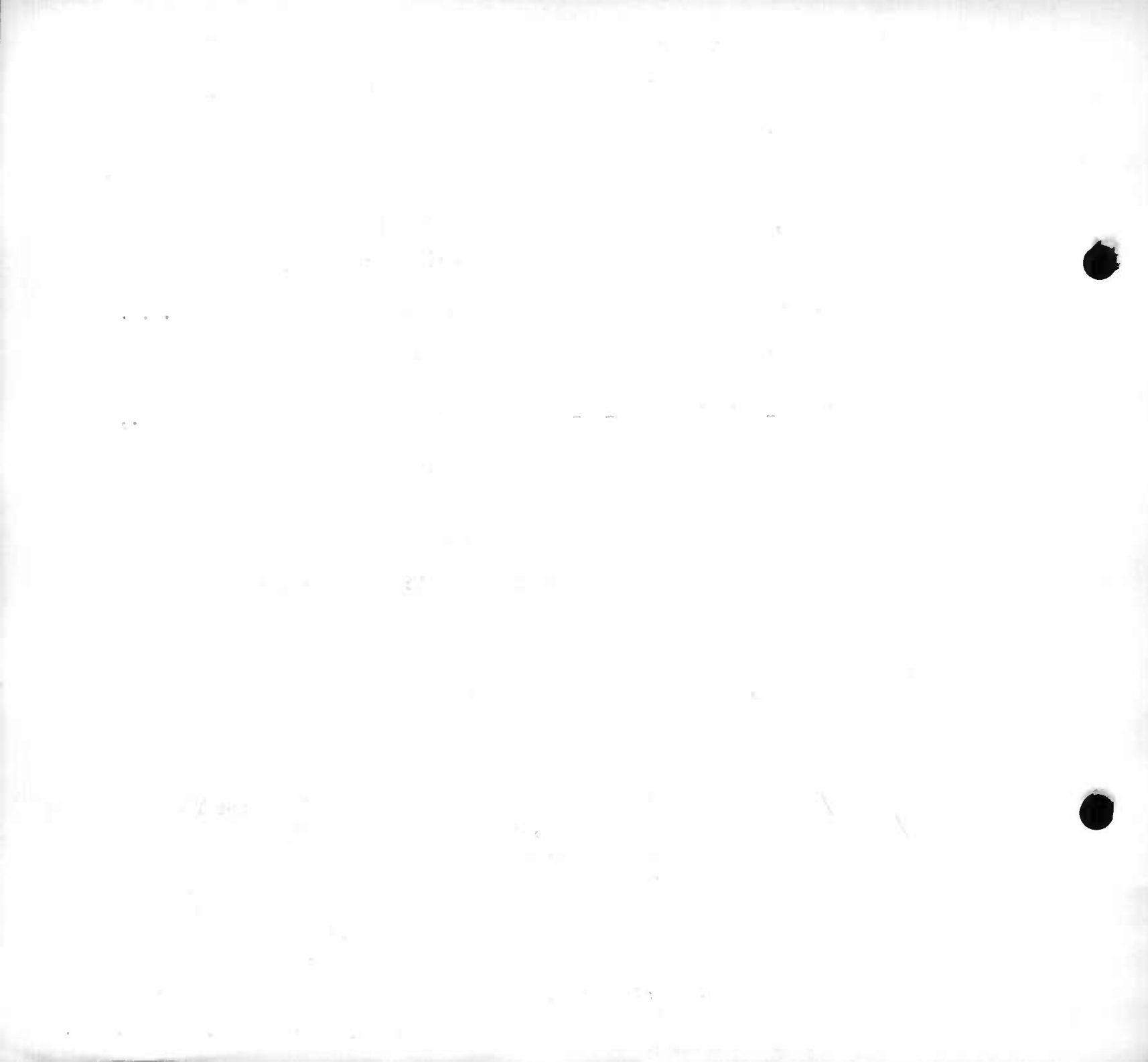
Wm Harrison

St. Louis, Mo.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                    |                                                                                               |                                                                                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| F-362 70 7934                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |                                    | REG. NO. 70 7934                                                                              |                                                                                                                          |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>FADROWSKI, Walter Richard</b>                                                                                     |                                    | 2. DATE AND HOUR OF DEATH<br><b>August 5, 1970.</b>                                           |                                                                                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                       |                                    | M.                                                                                            |                                                                                                                          |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>23 Veterans Administration Hospital<br/>3900 Loch Raven Boulevard<br/>Baltimore, Maryland 21218</b>                                                                                                                                                                                                                                                                                                                                              |                         | A. STATE<br><b>Maryland</b>                                                                                                                                 |                                    | <b>2734</b>                                                                                   |                                                                                                                          |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                                                                                                                                        |                         | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                         |                                    | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | E. STREET AND NUMBER<br><b>3716 Gibbons Avenue</b>                                                                                                          |                                    |                                                                                               |                                                                                                                          |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 6. RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/2/88</b> | 9. AGE (in years last birthday)<br><b>81</b>                                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Meat Cutter</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Poland</b>                                    |                                                                                                                          |
| 13. FATHER'S NAME<br><b>John Fadrowski</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 14. MOTHER'S MAIDEN NAME<br><b>Anna (NN unknown)</b>                                                                                                        |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                 |                                                                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes 7/7/17 - 9/27/19</b>                                                                                                                                                                                                                                                                                                                                                     |                         | 16. SOCIAL SECURITY NO.<br><b>220-07-1081</b>                                                                                                               |                                    | 17. INFORMANT<br><b>VA Hospital Records</b>                                                   |                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                    | ADDRESS<br><b>3900 Loch Raven Boulevard Balto., Md 21218</b>                                  |                                                                                                                          |
| 18. <b>207.91</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | CAUSE OF DEATH                                                                                                                                              |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |                                                                                                                          |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                                                                                              |                         | (A) IMMEDIATE CAUSE <b>Uremia</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                        |                                    |                                                                                               |                                                                                                                          |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                                                                                                                                              |                         | (B) <b>Renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                 |                                    |                                                                                               |                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | (C) <b>Leukemia uric acid nephropathy</b>                                                                                                                   |                                    |                                                                                               |                                                                                                                          |
| II                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | Obstructive jaundice                                                                                                                                        |                                    |                                                                                               |                                                                                                                          |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                    |                                                                                               |                                                                                                                          |
| 19A. DATE OF OPERATION<br><b>7/23/70</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>jaundice, &amp; CA of obstructive</b>                                                                |                                    | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                        |                                                                                                                          |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                     |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                                                                                                          |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                    | 21F. HOW DID INJURY OCCUR?                                                                    |                                                                                                                          |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 10th</b> 19 <b>70</b> to <b>August 5th</b> 19 <b>70</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 5, 1970</b> and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <b>view</b> the body after death. |                         |                                                                                                                                                             |                                    |                                                                                               |                                                                                                                          |
| 23A. SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                                                                       |                         | 23B. DATE SIGNED<br><b>8/6/70</b>                                                                                                                           |                                    |                                                                                               |                                                                                                                          |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 23D. ADDRESS<br><b>3900 Loch Raven Boulevard<br/>Baltimore, Md 21218</b>                                                                                    |                                    |                                                                                               |                                                                                                                          |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | 24B. DATE<br><b>8/10/70.</b>                                                                                                                                |                                    | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>                               |                                                                                                                          |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>AUG 10 1970</b>                                                                                                       |                                    | 25B. NAME OF REGISTRAR<br><b>Robert E. Jarboe, M.D.</b>                                       |                                                                                                                          |
| 25C. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |                         | 25D. ADDRESS                                                                                                                                                |                                    |                                                                                               |                                                                                                                          |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 7935

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br>MARIA A. CULOTTA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> August 8, 1970<br>Hour 2:23 A.M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>44 Union Memorial Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br>August 8, 1970<br>Hour 2:23 A.M.                                                                       |  |
| 6. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7. RACE<br>White                                                                                                                                    |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | C. CITY OR TOWN<br>Baltimore                                                                                                                        |  |
| 9. DATE OF BIRTH<br>1884<br>JULY 20th, 1884                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10. AGE (In years, lost birthday)<br>86<br>If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.                                                |  |
| 11. BIRTHPLACE (State or foreign country)<br>ITALY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                              |  |
| 13. FATHER'S NAME<br>VINCENT ILARDO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY 2632                          |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                   |  |
| 15. MOTHER'S MAIDEN NAME<br>MARIA DANTONI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO                                       |  |
| 17. SOCIAL SECURITY NO.<br>215-52-1402                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 18. INFORMANT<br>MR. VINCENT CULOTTA 4713 WOODLEA AVE.                                                                                              |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>E8801 X<br>FRACTURE OF NECK<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                        |  |
| 20A. DATE OF OPERATION<br>8-7-70                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                    |  |
| 21. AUTOPSY? (Yes or No)<br>Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                     |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>stairs                                                  |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br>4713 Woodlea Avenue 2632                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                     |  |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br>8-7-70 10:45 P.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                |  |
| 22F. HOW DID INJURY OCCUR?<br>Fell down basement stairs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                     |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE: Charles S. Springate, M.D.<br>EXAMINER'S NAME (Type)<br>Charles S. Springate, M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br>August 8, 1970 |  |                                                                                                                                                     |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 24B. DATE<br>8/11/70                                                                                                                                |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>HOLY REDEEMER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 24D. LOCATION (City, town, or county) (State)<br>BALTO. Md.                                                                                         |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>AUG 10 1970                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 25B. NAME OF REGISTRAR<br>Robert E. Farber, M.D.                                                                                                    |  |
| 25C. FUNERAL DIRECTOR<br>Frank J. Kelly                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | ADDRESS<br>322 S. HIGH ST.                                                                                                                          |  |

36

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

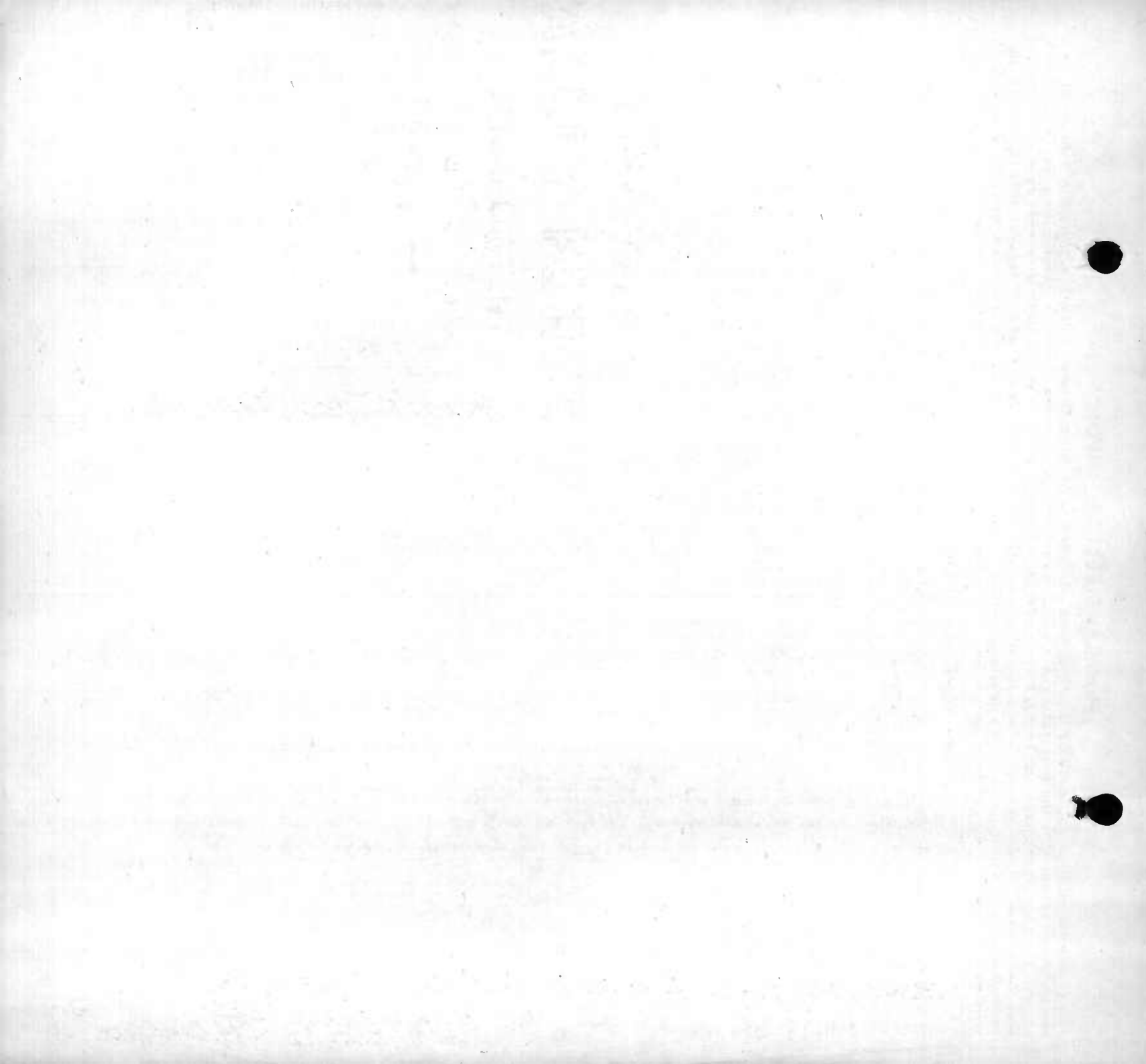
RECEIVED CIVIL RIGHTS DIVISION MAY 20 1964

RE: [illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                   |                                |                                                                                                                                                                                         |                                                                                                                                                                                                                              | REG. NO. <u>70 7936</u>                                                                                                                                                                                                                                                                                                                               |                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| <b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print) <u>Simpson, Robert</u>                                                                                                                                                                                                                                                                                                           |                                |                                                                                                                                                                                         |                                                                                                                                                                                                                              | <b>2. DATE AND HOUR OF DEATH</b><br><u>August 6, 1970</u> <u>6:45</u> P.M.                                                                                                                                                                                                                                                                            |                                                           |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Good Samaritan Hospital</u><br><u>5601 Loch Raven Boulevard</u><br><u>Baltimore, Maryland 21212</u>                                                                                                    |                                |                                                                                                                                                                                         |                                                                                                                                                                                                                              | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>21206</u><br><b>C. CITY OR TOWN</b> <u>Baltimore</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>E. STREET AND NUMBER</b><br><u>6616 Belair Rd.</u> |                                                           |
| <b>5. SEX</b><br><u>Male</u>                                                                                                                                                                                                                                                                                                                                                                       | <b>6. RACE</b><br><u>White</u> | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><u>12/19/81</u>                                                                                                                                                                                   | <b>9. AGE</b> (In years last birthday)<br><u>88</u>                                                                                                                                                                                                                                                                                                   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                 |                                |                                                                                                                                                                                         | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>VIRGINIA</u>                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                       | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>      |
| <b>13. FATHER'S NAME</b><br><u>GEORGE OLIVER SIMPSON</u>                                                                                                                                                                                                                                                                                                                                           |                                |                                                                                                                                                                                         | <b>14. MOTHER'S MAIDEN NAME</b><br><u>SALLY SECHRIST</u>                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                       |                                                           |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>                                                                                                                                                                                                                                                                       |                                |                                                                                                                                                                                         | <b>16. SOCIAL SECURITY NO.</b><br><u>21303 8086</u>                                                                                                                                                                          | <b>17. INFORMANT</b> <u>HERBERT R. JIMSON, BALTO, MD.</u> <b>ADDRESS</b>                                                                                                                                                                                                                                                                              |                                                           |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                  |                                |                                                                                                                                                                                         | <b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Gastro-enteritis - probably Salmonella</u><br>(B) <u>Acute renal failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>dehydration</u><br>(C) _____ |                                                                                                                                                                                                                                                                                                                                                       |                                                           |
| <b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):                                                                                                                                                                                                                                                      |                                |                                                                                                                                                                                         | <u>Generalized arteriosclerosis</u>                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                       |                                                           |
| <b>19A. DATE OF OPERATION</b>                                                                                                                                                                                                                                                                                                                                                                      |                                | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>                                                                                                                                 |                                                                                                                                                                                                                              | <b>20A. AUTOPSY?</b> (Yes or No) <u>Yes</u>                                                                                                                                                                                                                                                                                                           |                                                           |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <u>NO</u>                                                                                                                                                                                                                                                                                             |                                | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                         |                                                                                                                                                                                                                              | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                       |                                                           |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                                                                                   |                                | <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                           |                                                                                                                                                                                                                              | <b>21F. HOW DID INJURY OCCUR?</b>                                                                                                                                                                                                                                                                                                                     |                                                           |
| <b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>August 1st</u> <u>1970</u> <b>to</b> <u>August 6th</u> <u>1970</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>August 6th</u> <u>1970</u> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b> |                                |                                                                                                                                                                                         |                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                       |                                                           |
| <b>23A. SIGNATURE</b><br><u>M. Isabelle MacGregor</u>                                                                                                                                                                                                                                                                                                                                              |                                |                                                                                                                                                                                         |                                                                                                                                                                                                                              | <b>23B. DATE SIGNED</b><br><u>8-6-70</u>                                                                                                                                                                                                                                                                                                              |                                                           |
| <b>23C. PHYSICIAN'S NAME</b> (Type) <u>DR. TOMS</u>                                                                                                                                                                                                                                                                                                                                                |                                |                                                                                                                                                                                         |                                                                                                                                                                                                                              | <b>23D. ADDRESS</b>                                                                                                                                                                                                                                                                                                                                   |                                                           |
| <b>24A. BURIAL CREMATION REMOVAL</b> (Specify) <u>BURIAL/REM 8/10/70</u>                                                                                                                                                                                                                                                                                                                           |                                | <b>24B. DATE</b>                                                                                                                                                                        |                                                                                                                                                                                                                              | <b>24C. NAME OF CEMETERY or CREMATORY</b> <u>JEREMIAH BURIAL PARK</u>                                                                                                                                                                                                                                                                                 |                                                           |
| <b>24D. LOCATION</b> (City, town, or county) (State) <u>SALEM, VA.</u>                                                                                                                                                                                                                                                                                                                             |                                | <b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>AUG 11 1970</u>                                                                                                                               |                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                       |                                                           |
| <b>25B. NAME OF REGISTRAR</b> <u>Robert E. Taylor, M.D.</u>                                                                                                                                                                                                                                                                                                                                        |                                | <b>25C. FUNERAL DIRECTOR</b> <u>J. M. OAKLEY, JR.</u>                                                                                                                                   |                                                                                                                                                                                                                              | <b>ADDRESS</b> <u>REAR 14</u>                                                                                                                                                                                                                                                                                                                         |                                                           |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                       |                                                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                             | REG. NO. <span style="font-size: 1.5em;">70 7937</span>                                           |                                                                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                   |                                                                                              |
| 1. NAME OF DECEASED<br>(Type or Print)<br><div style="text-align: center; font-size: 1.2em;">Mary E. Renoff</div>                                                                                                                                                                                                                                                                                                                      |                                                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><div style="text-align: center;">August 6, 1970 <span style="float: right;">2<sup>10</sup> A.M.</span></div>                                                                                                                                                                                                                                                                                                                   |                                                                                                   |                                                                                              |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><div style="text-align: center; font-size: 1.2em;">Gould Convalesarium</div>                                                                                                                                                                                |                                                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <span style="font-size: 1.2em;">Maryland</span><br>B. COUNTY <span style="font-size: 1.5em;">907</span><br>C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <span style="font-size: 1.2em;">2814 The Alameda</span> |                                                                                                   |                                                                                              |
| 5. SEX<br><span style="font-size: 1.2em;">Female</span>                                                                                                                                                                                                                                                                                                                                                                                | 6. RACE<br><span style="font-size: 1.2em;">White</span> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><span style="font-size: 1.2em;">Sept. 25, 1884</span>                                                                                                                                                                                                                                                                                                                                                                                   | 9. AGE (In years last birthday)<br><span style="font-size: 1.2em;">85</span>                      | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">At home</span>                                                                                                                                                                                                                                                                                          |                                                         |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                   | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">Maryland</span> |
| 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">U.S.A.</span>                                                                                                                                                                                                                                                                                                                                                          |                                                         |                                                                                                                                                             | 13. FATHER'S NAME<br><span style="font-size: 1.2em;">John Snyder</span>                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                   |                                                                                              |
| 14. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                                                                                                                                                                               |                                                         |                                                                                                                                                             | 15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">No</span>                                                                                                                                                                                                                                                                                                    |                                                                                                   |                                                                                              |
| 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                |                                                         |                                                                                                                                                             | 17. INFORMANT<br><span style="font-size: 1.2em;">Severna, Md. Richard H. Renoff, 63 Riverside Drive,</span>                                                                                                                                                                                                                                                                                                                                                 |                                                                                                   |                                                                                              |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><div style="text-align: center; font-size: 1.2em;">003191</div><br><span style="font-size: 1.2em;">Acute gastroenteritis due to Salmonella inf.</span>                                                                           |                                                         |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><span style="font-size: 1.2em;">1 wk</span>                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                   |                                                                                              |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                                                                                         |                                                         |                                                                                                                                                             | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><span style="font-size: 1.2em;">Anteriosclerotic cardio-vascular disease</span><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><span style="font-size: 1.2em;">cerebral sclerosis, senility, confusion</span><br>(C) <span style="font-size: 1.2em;">many years</span>                                                                                                                                    |                                                                                                   |                                                                                              |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                       |                                                         |                                                                                                                                                             | II <span style="font-size: 1.2em;">cerebral sclerosis, senility, confusion</span>                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                   |                                                                                              |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 20A. AUTOPSY? (Yes or No)                                                                         |                                                                                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                  |                                                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                          |                                                                                              |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                              |                                                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 21F. HOW DID INJURY OCCUR?                                                                        |                                                                                              |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">May 6 1961</span> to <span style="font-size: 1.2em;">Aug 6 1970</span> and that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">July 15 1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                   |                                                                                              |
| 23A. SIGNATURE<br><span style="font-size: 1.2em;">Hans K. Koetter</span>                                                                                                                                                                                                                                                                                                                                                               |                                                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">Aug 7, 1970</span>                            |                                                                                              |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.2em;">Hans K. Koetter, M.D.</span>                                                                                                                                                                                                                                                                                                                                           |                                                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 23D. ADDRESS<br><span style="font-size: 1.2em;">5600 Harford Road,</span>                         |                                                                                              |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">Burial</span>                                                                                                                                                                                                                                                                                                                                              |                                                         | 24B. DATE<br><span style="font-size: 1.2em;">8/8/70</span>                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 24C. NAME OF CEMETERY OR CREMATORY<br><span style="font-size: 1.2em;">Loudon Park Cemetery</span> |                                                                                              |
| 24D. LOCATION<br><span style="font-size: 1.2em;">Baltimore, Md.</span>                                                                                                                                                                                                                                                                                                                                                                 |                                                         | 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.2em;">AUG 11 1970</span>                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                   |                                                                                              |
| 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">Robert E. Farber, M.D.</span>                                                                                                                                                                                                                                                                                                                                                |                                                         | 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.2em;">Ullrich Funeral Home 4210 Belair Road.</span>                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                   |                                                                                              |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 70 7938                                                                                                                                                                                                                                                                                                        |                  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |                                   | REG. NO. 70 7938                                                                              |                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                      |                  | 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                      |                                   | 2. DATE AND HOUR OF DEATH                                                                     |                                                           |
|                                                                                                                                                                                                                                                                                                                |                  | Ellen Pridham                                                                                                                                               |                                   | August 7, 1970                                                                                |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                         |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                       |                                   | M.                                                                                            |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>90 Gould Convalesarium                                                                                                                                                                                                                                                 |                  | A. STATE<br>Maryland                                                                                                                                        |                                   | B. COUNTY                                                                                     |                                                           |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                           |                  | C. CITY OR TOWN<br>Baltimore                                                                                                                                |                                   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                           |
|                                                                                                                                                                                                                                                                                                                |                  | E. STREET AND NUMBER<br>5640 Belair Road                                                                                                                    |                                   | 94 <sup>th</sup> Am                                                                           |                                                           |
| 5. SEX<br>Female                                                                                                                                                                                                                                                                                               | 6. RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>July 12, 1870 | 9. AGE (In years last birthday)<br>100                                                        | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>At home                                                                                                                                                                                                         |                  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                   | 11. BIRTHPLACE (State or foreign country)<br>England                                          |                                                           |
| 13. FATHER'S NAME<br>?                                                                                                                                                                                                                                                                                         |                  | 14. MOTHER'S MAIDEN NAME<br>?                                                                                                                               |                                   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                        |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                 |                  | 16. SOCIAL SECURITY NO.<br>220-46-1317 T                                                                                                                    |                                   | 17. INFORMANT<br>Anthony G. Bitter, 5640 Belair Road                                          |                                                           |
| 18. 009.21                                                                                                                                                                                                                                                                                                     |                  | CAUSE OF DEATH                                                                                                                                              |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |                                                           |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                  |                  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Enteritis Infectiosa                                                                              |                                   |                                                                                               |                                                           |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                 |                  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br>Arterio Sclerosis                                                                                                    |                                   |                                                                                               |                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                         |                  | (C) DUE TO, OR AS A CONSEQUENCE OF:<br>Secondary Anemia                                                                                                     |                                   |                                                                                               |                                                           |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                         |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                   | 20A. AUTOPSY? (Yes or No)                                                                     |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)                                                                                                                                                                                                                          |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                                           |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                      |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                   | 21F. HOW DID INJURY OCCUR?                                                                    |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from July 10 1970 to Aug. 7 1970 that (I) (we) last saw the deceased alive on Aug 7 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |                                                                                                                                                             |                                   |                                                                                               |                                                           |
| 23A. SIGNATURE<br>Walter A. Anderson                                                                                                                                                                                                                                                                           |                  | 23B. DATE SIGNED<br>8/8/70                                                                                                                                  |                                   | 23C. PHYSICIAN'S NAME (Type)<br>W.A. Anderson, M.D.                                           |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                             |                  | 24B. DATE<br>8/10/70                                                                                                                                        |                                   | 24C. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery                                       |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br>AUG 11 1970                                                                                                                                                                                                                                                                 |                  | 25B. NAME OF REGISTRAR<br>Robert E. Farber M.D.                                                                                                             |                                   | 25C. FUNERAL DIRECTOR<br>Ullrich Funeral Home, 4210 Belair Road.                              |                                                           |
| 25D. ADDRESS                                                                                                                                                                                                                                                                                                   |                  | 25E. ADDRESS                                                                                                                                                |                                   | 25F. ADDRESS                                                                                  |                                                           |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                                                                                                                                                                                                                                                                        |                                           | REG. NO. <u>70 7939</u>                                                                                |                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| U-462 <u>70 7939</u>                                                                                                                                                                                                                                                                                                                               |                         | <b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                        |                                                           |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                          |                         | 1. NAME OF DECEASED<br>(Type or Print) <u>Elizabeth Ulrich</u>                                                                                                                                                                                                                                                                                                                                         |                                           | 2. DATE AND HOUR OF DEATH<br><u>August 6, 1970</u> <u>2:55 A.M.</u>                                    |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Gould Convalesarium</u>                                                                                                                                              |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>831</u><br>C. CITY OR TOWN <u>Baltimore</u><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>2876 Pelham Ave.</u>                                                                            |                                           |                                                                                                        |                                                           |
| 5. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                            | 6. RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                            | 8. DATE OF BIRTH<br><u>Sept. 26, 1880</u> | 9. AGE (In years last birthday)<br><u>89</u>                                                           | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>At home</u>                                                                                                                                                                                                                                      |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                      |                                           | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                           |                                                           |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                                                                                                                                                                                                                      |                         | 13. FATHER'S NAME<br><u>Alexander Mohr</u>                                                                                                                                                                                                                                                                                                                                                             |                                           | 14. MOTHER'S MAIDEN NAME<br><u>Caroline Mattes</u>                                                     |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                              |                         | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                |                                           | 17. INFORMANT ADDRESS<br><u>Mrs. Theodore H. Ullrich, 2401 Chesterfield.</u>                           |                                                           |
| 18. <u>4379 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or compulsion which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                         | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <u>Cerebral arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <u>Generalized arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____                                                                                                                                                                                                   |                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>?</u><br><u>?</u><br><u>?</u>                       |                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                             |                         | <u>Depression Psychosis</u>                                                                                                                                                                                                                                                                                                                                                                            |                                           | <u>?</u>                                                                                               |                                                           |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                 |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                                                       |                                           | 20A. AUTOPSY? (Yes or No)                                                                              |                                                           |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                               |                         | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                         |                                           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                                           |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                           |                         | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                              |                                           | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                                           |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                         |                         | 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>Sept. 19 69</u> to <u>Aug. 6 19 70</u> that (I) ( <del>we</del> ) last saw the deceased alive on <u>Aug. 5 19 70</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death. |                                           |                                                                                                        |                                                           |
| 23A. SIGNATURE<br><u>Louis F. Klimes M.D.</u>                                                                                                                                                                                                                                                                                                      |                         | 23B. DATE SIGNED<br><u>Aug. 7, 1970</u>                                                                                                                                                                                                                                                                                                                                                                |                                           | 23C. PHYSICIAN'S NAME (Type)<br><u>Louis F. Klimes, M.D.</u>                                           |                                                           |
| 23D. ADDRESS<br><u>4814 Bowleys Lane</u>                                                                                                                                                                                                                                                                                                           |                         | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                              |                                           | 24B. DATE<br><u>8/8/70</u>                                                                             |                                                           |
| 24C. NAME OF CEMETERY OR CREMATORY<br><u>Parkwood Cemetery</u>                                                                                                                                                                                                                                                                                     |                         | 24D. LOCATION (City, town, or county) (State)<br><u>Parkville, Md.</u>                                                                                                                                                                                                                                                                                                                                 |                                           | 25A. DATE REC'D BY HEALTH DEPT.<br><u>AUG 11 1970</u>                                                  |                                                           |
| 25B. NAME OF REGISTRAR<br><u>Robert E. Fisher, M.D.</u>                                                                                                                                                                                                                                                                                            |                         | 25C. FUNERAL DIRECTOR<br><u>Ullrich Funeral Home</u>                                                                                                                                                                                                                                                                                                                                                   |                                           | 25D. ADDRESS<br><u>4210 Belair Road.</u>                                                               |                                                           |

THE UNIVERSITY OF CHICAGO



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| J-520 70 7940                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                 |                                           | REG. NO. 70 7940                                                                                                                |  |
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| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |  | CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                             |                                           |                                                                                                                                 |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Rose M Jones</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br>8/9/70 2:55 a. M.                                                                                                                                                                                                                                                                                   |                                           |                                                                                                                                 |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>The Johns Hopkins Hospital</u>                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>704</u><br>C. CITY OR TOWN <u>Baltimore</u><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>944 N. Washington St.</u> |                                           |                                                                                                                                 |  |
| 5. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 6. RACE<br><u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>2/6/27</u>                                                                                                                                                                                                                                                                                                | 9. AGE (In years last birthday) <u>43</u> | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min.                                                                       |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Laundress</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |  | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore Md.</u>                                                                                                                                                                                                                                                                |                                           | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                   |  |
| 13. FATHER'S NAME<br><u>Thomas Hamilton</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br><u>Dora Trent</u>                                                                                                                                                                                                                                                                                    |                                           |                                                                                                                                 |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |  | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                          |                                           | 17. INFORMANT<br><u>Dora Hamilton</u> ADDRESS <u>944 Washington St</u>                                                          |  |
| 18. <u>486X 17-303.2</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><u>Coronary Artery</u><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <u>Chronic Alcoholism</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr</u><br><u>3d</u><br><u>6d</u> |                         |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                  |                                           |                                                                                                                                 |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><u>Chronic Alcoholism</u>                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                  |                                           |                                                                                                                                 |  |
| 19A. DATE OF OPERATION<br><u>2</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)<br><u>Yes</u>                                                                                                                                                                                                                                                                                          |                                           | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                            |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                         |                                           |                                                                                                                                 |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                       |                                           |                                                                                                                                 |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8/9</u> 19 <u>70</u> to <u>8/9</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>8/9</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                  |                                           |                                                                                                                                 |  |
| 23A. SIGNATURE<br><u>Michael H. Merson</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |  | 23B. DATE SIGNED<br><u>8/9/70</u>                                                                                                                                                                                                                                                                                                |                                           | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Michael H. Merson, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |  | 23D. ADDRESS<br><u>The Johns Hopkins Hospital</u>                                                                                                                                                                                                                                                                                |                                           |                                                                                                                                 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 24B. DATE<br><u>8/13/70</u>                                                                                                                                 |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Arbutus Mem. Park</u>                                                                                                                                                                                                                                                                   |                                           | 24D. LOCATION (City, town, or county) (State)<br><u>Arbutus, Md.</u>                                                            |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>AUG 11 1970</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor, M.D.</u>                                                                                                     |  | 25C. FUNERAL DIRECTOR<br><u>James C. Clark</u>                                                                                                                                                                                                                                                                                   |                                           | ADDRESS<br><u>1129 N. Carroll</u>                                                                                               |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| A-535 70 7941                                                                                                                                                                                                                                                                                                                               |               | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |                                                                                                                                                                                                                             | REG. NO. 70 7941                                                         |                                                                                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                   |               | CERTIFICATE OF DEATH                                                                                                                                        |                                                                                                                                                                                                                             |                                                                          |                                                                                                                |
| 1. NAME OF DECEASED<br>(Type or Print) Jackson Anthony                                                                                                                                                                                                                                                                                      |               |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br>8-9-1970 4.15A M.                                                                                                                                                                              |                                                                          |                                                                                                                |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                      |               |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                                                                                       |                                                                          |                                                                                                                |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>31 Baltimore City Hospitals<br>4940 Eastern Avenue<br>Baltimore, Maryland 21224                                                                                                                                                                                                                     |               |                                                                                                                                                             | A. STATE Maryland<br>C. CITY OR TOWN Baltimore<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 2212 East Chase Street 21213                           |                                                                          |                                                                                                                |
| 5. SEX Male                                                                                                                                                                                                                                                                                                                                 | 6. RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-6-1915                                                                                                                                                                                                  | 9. AGE (in years last birthday) 54                                       | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Worker</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Sancti S. C.</u>                                                                                                                                                                                                                                                                               |               |                                                                                                                                                             | 12. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                |                                                                          |                                                                                                                |
| 13. FATHER'S NAME Patterson Anthony                                                                                                                                                                                                                                                                                                         |               |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME Maggie Rhodes                                                                                                                                                                                      |                                                                          |                                                                                                                |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>                                                                                                                                                                                                                          |               |                                                                                                                                                             | 16. SOCIAL SECURITY NO. 247-24-8758                                                                                                                                                                                         |                                                                          |                                                                                                                |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                                               |               |                                                                                                                                                             | ADDRESS Records: BCH-4940 Eastern Avenue 21224                                                                                                                                                                              |                                                                          |                                                                                                                |
| 18. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                          |               |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                |                                                                          |                                                                                                                |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.            |               |                                                                                                                                                             | (A) IMMEDIATE CAUSE <u>Cerebrovascular accident</u> 2 months<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <u>atrial fibrillation</u> 4 yrs<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <u>Cardiomyopathy, type unknown</u> 4 yrs |                                                                          |                                                                                                                |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                      |               |                                                                                                                                                             | <u>arteriosclerotic vascular disease</u> ?                                                                                                                                                                                  |                                                                          |                                                                                                                |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                      |               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                             | 20A. AUTOPSY (Yes or No) <u>no</u>                                       |                                                                                                                |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                       |               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                             | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                                                                                |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                   |               | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                                                                                                             | 21F. HOW DID INJURY OCCUR?                                               |                                                                                                                |
| 22. I certify that (this hospital) attended the deceased from <u>7-23</u> 19 <u>70</u> to <u>8/9</u> 19 <u>70</u> that (we) last saw the deceased alive on <u>8/9</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |               |                                                                                                                                                             |                                                                                                                                                                                                                             |                                                                          |                                                                                                                |
| 23A. SIGNATURE <u>Henry Herrera M.D.</u>                                                                                                                                                                                                                                                                                                    |               |                                                                                                                                                             |                                                                                                                                                                                                                             | 23B. DATE SIGNED 8-9-1970                                                |                                                                                                                |
| 23C. PHYSICIAN'S NAME (Type) HENRY HERRERA, M.D.                                                                                                                                                                                                                                                                                            |               | 23D. ADDRESS 4940 Baltimore City Hospitals Eastern Ave. Baltimore, Md. 21224                                                                                |                                                                                                                                                                                                                             |                                                                          |                                                                                                                |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>                                                                                                                                                                                                                                                                                      |               | 24B. DATE 8/12/70                                                                                                                                           |                                                                                                                                                                                                                             | 24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem Park</u>               |                                                                                                                |
| 24D. LOCATION (City, town, or county) <u>Arbutus Md.</u>                                                                                                                                                                                                                                                                                    |               | 24E. FUNERAL DIRECTOR <u>Frank L. Chick</u>                                                                                                                 |                                                                                                                                                                                                                             |                                                                          |                                                                                                                |
| 25A. DATE REC'D BY HEALTH/DEPT. <u>AUG 11 1970</u>                                                                                                                                                                                                                                                                                          |               | 25B. NAME OF REGISTRAR <u>Robert E. Faber</u>                                                                                                               |                                                                                                                                                                                                                             | 25C. ADDRESS <u>4129 N. Paulina St.</u>                                  |                                                                                                                |



## FUNERAL DIRECTOR: IMPORTANT

DR SPRINGATE OF THE MEDICAL EXAMINER'S OFFICE  
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

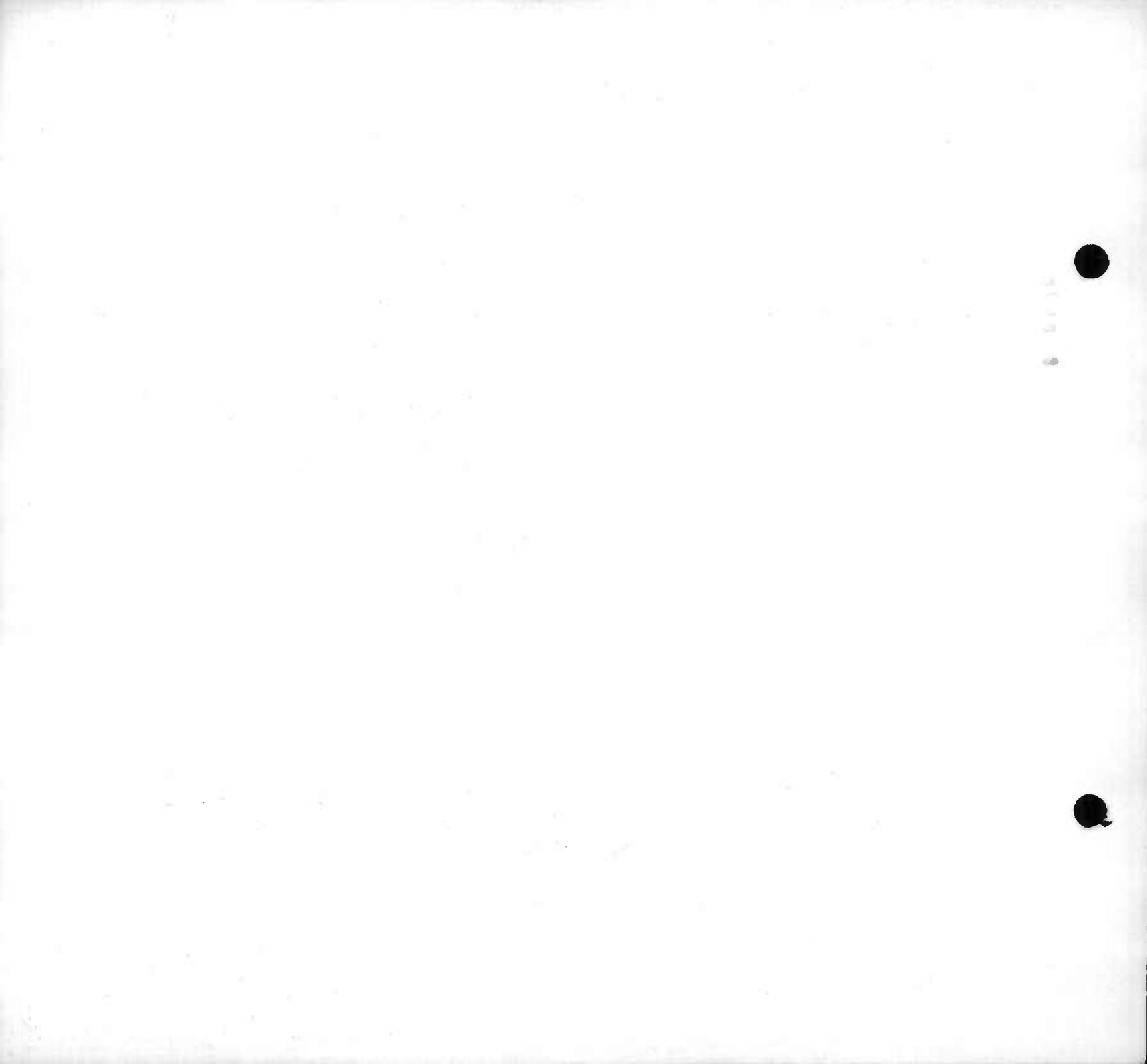
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| S-630                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 70 7942                                                                                                                                                     |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                              |  | REG. NO. 70 7942                                                                              |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                             |  | 1. NAME OF DECEASED<br>(Type or Print) <b>FRAZIER SEWARD</b>                                                                                                                                                  |  |                                                                                               |  |
| 2. DATE AND HOUR OF DEATH<br><b>8/9/70 2:55 A.M.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                                             |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                        |  |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Johns Hopkins Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  |                                                                                                                                                             |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                          |  |                                                                                               |  |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>806</b>                                                                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                             |  | C. CITY OR TOWN <b>Baltimore</b>                                                                                                                                                                              |  |                                                                                               |  |
| D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                                             |  | E. STREET AND NUMBER <b>1925 E Lafayette Ave</b>                                                                                                                                                              |  |                                                                                               |  |
| 5. SEX <b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 6. RACE <b>N</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>7/2/04</b>                                                                                                                                                                                |  | 9. AGE (In years last birthday) <b>66</b>                                                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Porter</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |                  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |  | 11. BIRTHPLACE (State or foreign country) <b>Va.</b>                                                                                                                                                          |  | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>                                                     |  |
| 13. FATHER'S NAME <b>Edward Seward</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME <b>Louina Hicks</b>                                                                                                                                                                  |  |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                             |  | 16. SOCIAL SECURITY NO.                                                                                                                                                                                       |  | 17. INFORMANT <b>Carrie Seward</b> ADDRESS <b>1925 E Lafayette Ave</b>                        |  |
| 18. <b>410.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>prostatic cancer metastatic</b> |                  |                                                                                                                                                             |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>Prostatic Cancer</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>years</b><br><b>years</b> |  |
| MEDICAL CERTIFICATION<br>19A. DATE OF OPERATION <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                             |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                              |  | 20A. AUTOPSY? (Yes or No) <b>No</b>                                                           |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                                             |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                      |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                                             |  | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                             |  | 21F. HOW DID INJURY OCCUR?                                                                    |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>August 9 1970</b> to <b>August 9 1970</b> that (I) (we) last saw the deceased alive on <b>August 9 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                     |                  |                                                                                                                                                             |  |                                                                                                                                                                                                               |  |                                                                                               |  |
| 23A. SIGNATURE <b>Ira Alan Morris MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                                             |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>                                                                               |  | 23B. DATE SIGNED <b>8/9/70</b>                                                                |  |
| 23C. PHYSICIAN'S NAME (Type) <b>Ira Alan Morris MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                             |  | 23D. ADDRESS <b>Johns Hopkins Hospital Baltimore</b>                                                                                                                                                          |  |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  | 24B. DATE <b>8/13/70</b>                                                                                                                                    |  | 24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>                                                                                                                                                   |  | 24D. LOCATION (City, town, or county) (State) <b>Arbutus Mem. Park</b>                        |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>AUG 11 1970</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>                                                                                                              |  | 25C. FUNERAL DIRECTOR <b>Milton E. Ellickson</b> ADDRESS <b>1129 N. ...</b>                                                                                                                                   |  |                                                                                               |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                     |                      |                                                                                                        |                                | REG. NO. <u>70 7943</u>                                                                    |                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------------------|---------------------------------|
| E-425 70 7943                                                                                                                                                                                                                                                                                                                                                        |                      | CERTIFICATE OF DEATH                                                                                   |                                |                                                                                            |                                 |
| BIRTH NO. <u>WILLIAM HENRY ELLISON</u>                                                                                                                                                                                                                                                                                                                               |                      | 2. DATE AND HOUR OF DEATH <u>8/3/70</u> <u>7 10</u> P.M.                                               |                                |                                                                                            |                                 |
| 1. NAME OF DECEASED (Type or Print)                                                                                                                                                                                                                                                                                                                                  |                      | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                 |                                |                                                                                            |                                 |
| FULL NAME OF HOSPITAL OR INSTITUTION                                                                                                                                                                                                                                                                                                                                 |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                  |                                |                                                                                            |                                 |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION                                                                                                                                                                                                                                                                                                   |                      | A. STATE <u>Maryland</u>                                                                               |                                | B. COUNTY <u>1001</u>                                                                      |                                 |
| The Johns Hopkins Hospital                                                                                                                                                                                                                                                                                                                                           |                      | C. CITY OR TOWN <u>Baltimore</u>                                                                       |                                | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                 |
|                                                                                                                                                                                                                                                                                                                                                                      |                      | E. STREET AND NUMBER <u>717 E. Preston Street</u>                                                      |                                |                                                                                            |                                 |
| 5. SEX <u>Male</u>                                                                                                                                                                                                                                                                                                                                                   | 6. RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                  | 8. DATE OF BIRTH <u>6/4/22</u> | 9. AGE (in years last birthday) <u>48</u>                                                  | 10. If Under 1 Yr. Months Days  |
|                                                                                                                                                                                                                                                                                                                                                                      |                      | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                     |                                |                                                                                            | 11. If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                          |                      | 10B. KIND OF BUSINESS OR INDUSTRY                                                                      |                                | 11. BIRTHPLACE (State or foreign country)                                                  |                                 |
| <u>Extremator</u>                                                                                                                                                                                                                                                                                                                                                    |                      |                                                                                                        |                                | <u>South Carolina</u>                                                                      |                                 |
| 13. FATHER'S NAME <u>Thomas Ellison</u>                                                                                                                                                                                                                                                                                                                              |                      | 14. MOTHER'S MAIDEN NAME <u>Pearl McCall</u>                                                           |                                | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                                 |                                 |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                             |                      | 16. SOCIAL SECURITY NO.                                                                                |                                | 17. INFORMANT ADDRESS                                                                      |                                 |
|                                                                                                                                                                                                                                                                                                                                                                      |                      |                                                                                                        |                                | <u>Mary Lee Ellison 717 E. Preston St.</u>                                                 |                                 |
| 18. <u>150X I</u>                                                                                                                                                                                                                                                                                                                                                    |                      | CAUSE OF DEATH                                                                                         |                                |                                                                                            |                                 |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                                       |                      | (A) IMMEDIATE CAUSE <u>Respiratory Arrest</u>                                                          |                                |                                                                                            |                                 |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                         |                      | DUE TO, OR AS A CONSEQUENCE OF:                                                                        |                                |                                                                                            |                                 |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                    |                      | (B) <u>CACHEXIA</u>                                                                                    |                                |                                                                                            |                                 |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                                                            |                      | DUE TO, OR AS A CONSEQUENCE OF:                                                                        |                                |                                                                                            |                                 |
|                                                                                                                                                                                                                                                                                                                                                                      |                      | (C) <u>Esophageal Ca.</u>                                                                              |                                |                                                                                            |                                 |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                     |                      |                                                                                                        |                                |                                                                                            |                                 |
| 19A. DATE OF OPERATION <u>2</u>                                                                                                                                                                                                                                                                                                                                      |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                                | 20A. AUTOPSY? (Yes or No) <u>Yes</u>                                                       |                                 |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)                                                                                                                                                                                                                                                                             |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                   |                                 |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                            |                      | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                | 21F. HOW DID INJURY OCCUR?                                                                 |                                 |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>8/3</u> <u>1970</u> to <u>8/3</u> <u>1970</u> that (I) <u>last</u> saw the deceased alive on <u>8/3</u> <u>1970</u> and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>last</u> (did) <u>not</u> view the body after death. |                      |                                                                                                        |                                |                                                                                            |                                 |
| 23A. SIGNATURE <u>Anthony Jackson</u>                                                                                                                                                                                                                                                                                                                                |                      | 23B. DATE SIGNED <u>8/3/70</u>                                                                         |                                | 23C. PHYSICIAN'S NAME (Type) <u>ANTHONY JACKSON</u>                                        |                                 |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>                                                                                                                                                                                                                                                                                                               |                      | 24B. DATE <u>8/8/70</u>                                                                                |                                | 24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>                                  |                                 |
| 24D. LOCATION (City, town, or county) <u>Bethesda, Md.</u>                                                                                                                                                                                                                                                                                                           |                      | 24E. NAME OF REGISTRAR <u>Elliot Funeral Home</u>                                                      |                                | 24F. FUNERAL DIRECTOR ADDRESS <u>1129 Madison V.</u>                                       |                                 |
| 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 11 1970</u>                                                                                                                                                                                                                                                                                                                   |                      | 25B. NAME OF REGISTRAR <u>Robert E. Toles, Jr.</u>                                                     |                                | 25C. FUNERAL DIRECTOR ADDRESS <u>1129 Madison V.</u>                                       |                                 |



G-426

70

7944

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

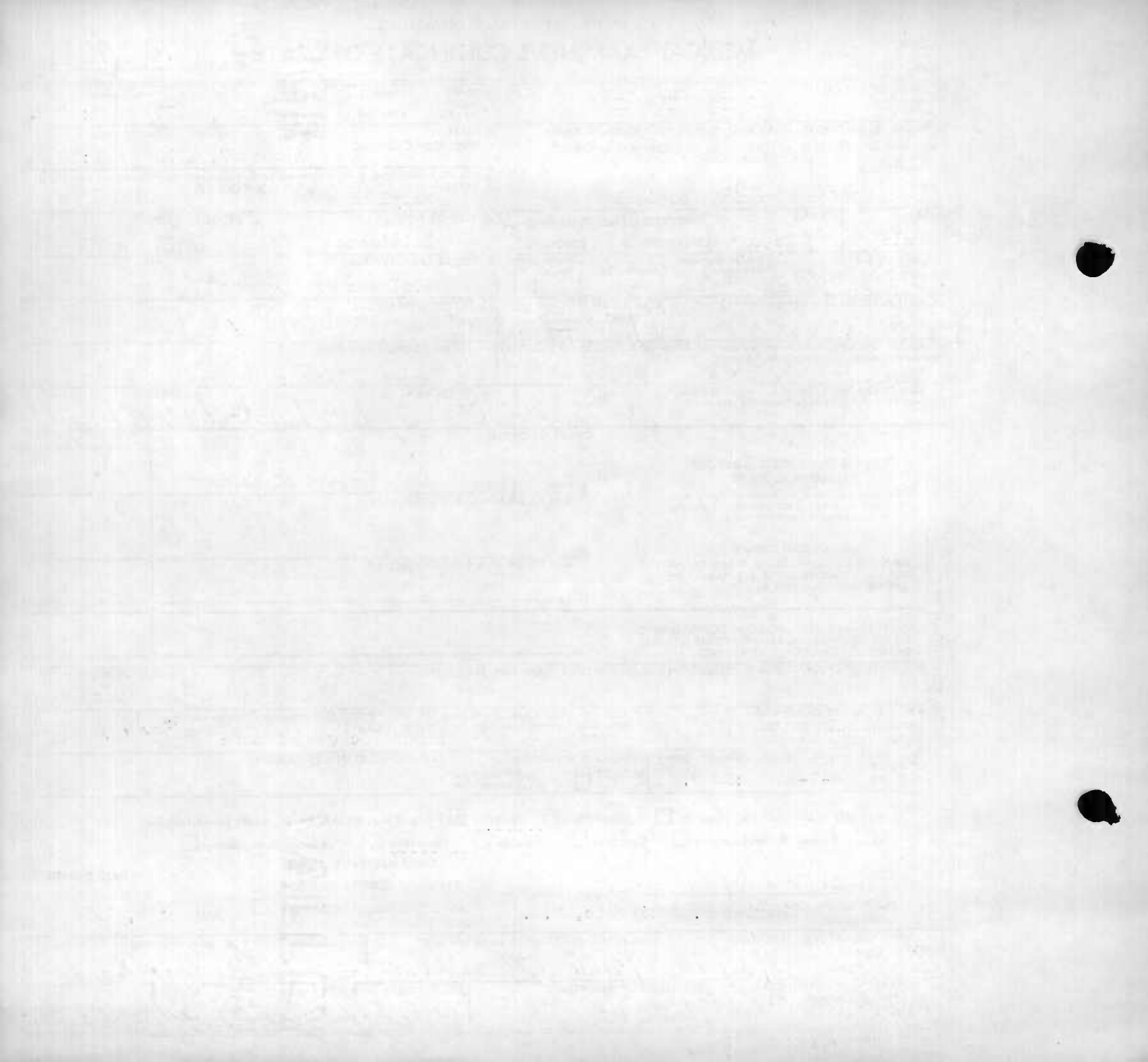
REG. NO.

70

7944

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) HENRY GILCHRIST Jr.                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour<br>August 7, 1970 8:10 P.M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>44 Union Memorial Hospital                                                                                                                                                                                                                                                                                                                                                               |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>August 7, 1970 8:10 P.M.                                                                       |  |
| 6. SEX Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 7. RACE Negro                                                                                                                                    |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                   |  | C. CITY OR TOWN Baltimore                                                                                                                        |  |
| 9. DATE OF BIRTH April 21, 1952                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10. AGE (In years last birthday) 18                                                                                                              |  |
| 11. BIRTHPLACE (State or foreign country) Balto. Md.                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                                              |  |
| 13. FATHER'S NAME Henry Gilchrist Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed                                            |  |
| 15. MOTHER'S MARDEN NAME Daisy Stanbury                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                          |  |
| 17. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 18. INFORMANT Daisy Gilchrist-4727 Wrenwood                                                                                                      |  |
| 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |  | (A) IMMEDIATE CAUSE<br>Gunshot wound of abdomen<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C)                 |  |
| 20A. DATE OF OPERATION 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                            |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                         |  |
| 22D. TIME OF INJURY (APPROX.) 8-7-70 6:30 P.                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 815 Richwood Avenue                                                                                                                                                                                                                                                                                                                                                                                               |  | 22F. HOW DID INJURY OCCUR? ?                                                                                                                     |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                              |  |                                                                                                                                                  |  |
| ACTUAL SIGNATURE Charles S. Springate M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                                                  |  |
| EXAMINER'S NAME (Type) Charles S. Springate, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>                                                                                              |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 24B. DATE 8/12/70                                                                                                                                |  |
| 24C. NAME OF CEMETERY or CREMATORY Balto. National Cem.                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 24D. LOCATION (City, town, or county) (State) 5501 Fredrick Ave Md.                                                                              |  |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 11 1970                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 25B. NAME OF REGISTRAR Robert E. Fabelo                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 25C. FUNERAL DIRECTOR ADDRESS G. S. Chilton - 1129 N. Caroline                                                                                   |  |

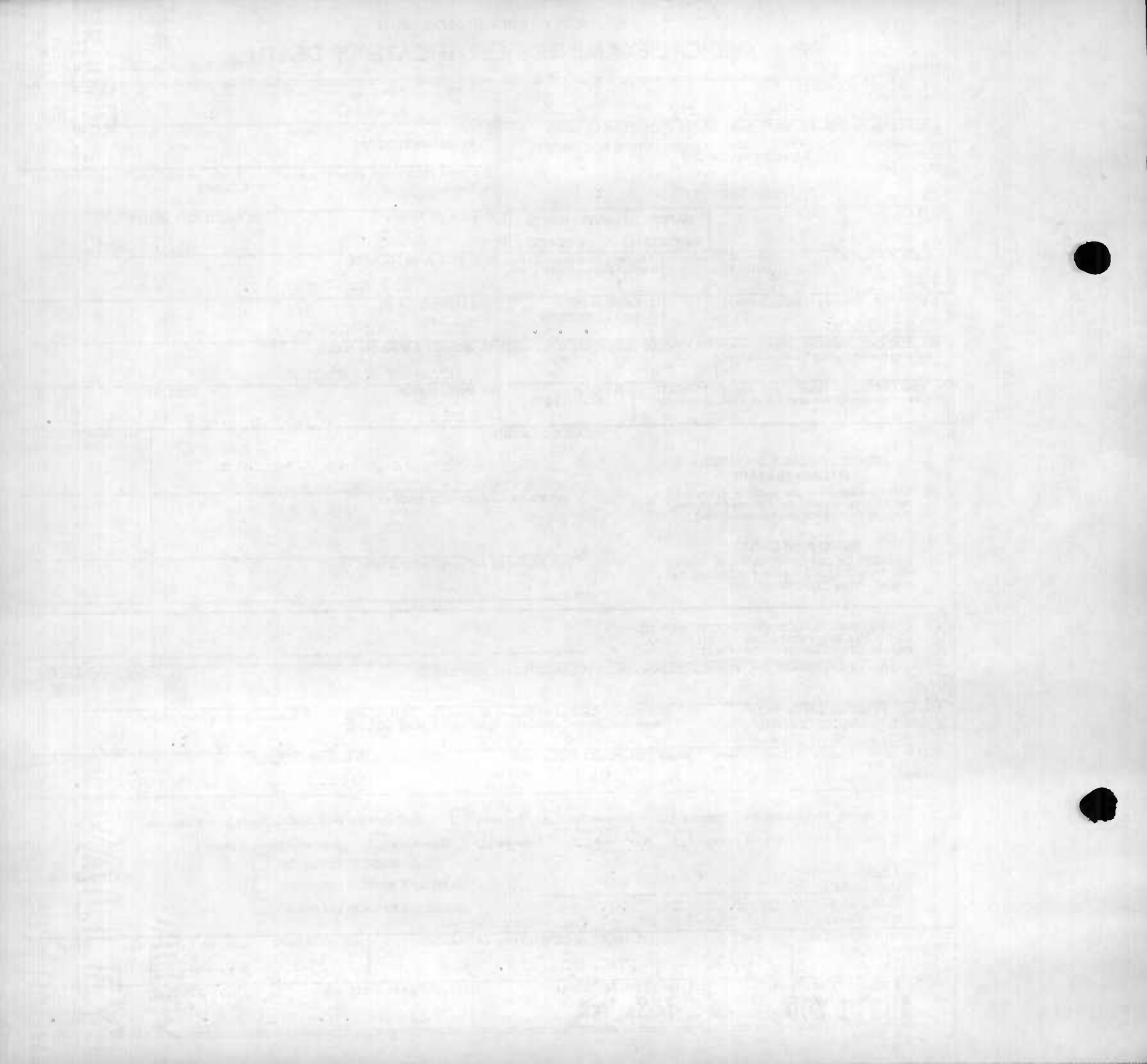


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

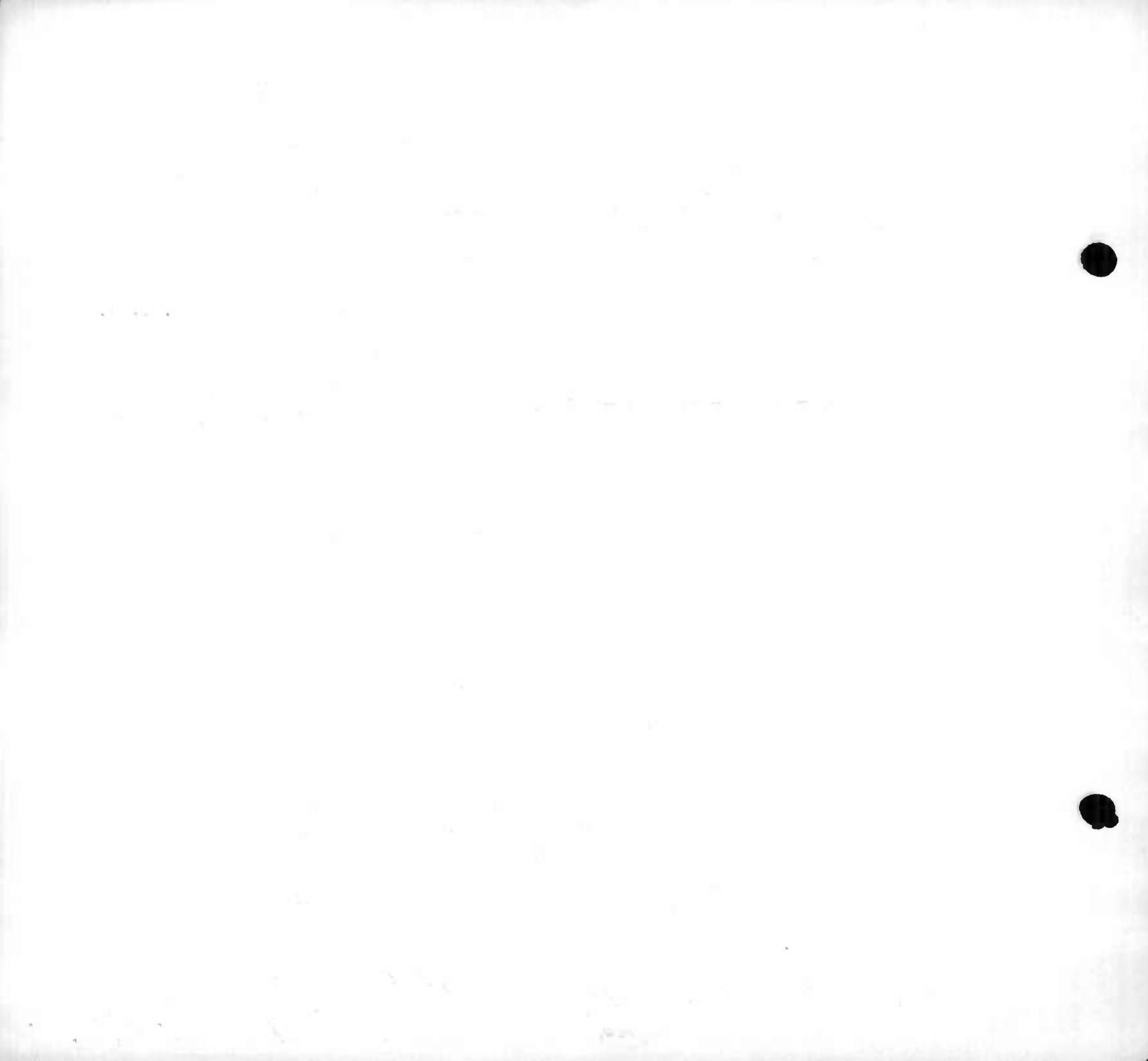
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br>Rene Lowery                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br>8 4 70 4:30 a.m.                                                        |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>48 Maryland General Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>8 4 70 4:30 a.m.                                                                                                                      |  |
| 6. SEX<br>female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 7. RACE<br>Negro                                                                                                                                                                        |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)<br>A. STATE Md. B. COUNTY 1501                                                                    |  |
| 9. DATE OF BIRTH<br>1/8/59                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10. AGE (in years last birthday)<br>11                                                                                                                                                  |  |
| 11. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                  |  |
| 13. FATHER'S NAME<br>Irvin Jackson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 14. MOTHER'S MAIDEN NAME<br>Garlethia Diggs                                                                                                                                             |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 16. SOCIAL SECURITY NO.                                                                                                                                                                 |  |
| 17. INFORMANT<br>Marietta Smith                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 18. ADDRESS<br>3902 Reistertown Rd.                                                                                                                                                     |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>E890X                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | CAUSE OF DEATH<br>Burns of most of body surface<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |  |
| 20. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 21. AUTOPSY? (Yes or No)<br>no                                                                                                                                                          |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Home                                                                                        |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>1534 N. Carey St. 1501                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)<br>8 4 70 ?                                                                                                                   |  |
| 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 22F. HOW DID INJURY OCCUR?<br>Subject burned in house fire.                                                                                                                             |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE: [Signature] M.D.<br>EXAMINER'S NAME (Type) Deputy Chief Medical Examiner<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED 8/4/70 |  |                                                                                                                                                                                         |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 24B. DATE<br>8/10/70                                                                                                                                                                    |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>Arbutus Mem. Park                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland                                                                                                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>AUG 11 1970                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, M.D.                                                                                                                                        |  |
| 25C. FUNERAL DIRECTOR<br>Kelson F.H.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 25D. ADDRESS<br>1348 N. Calhoun St.                                                                                                                                                     |  |



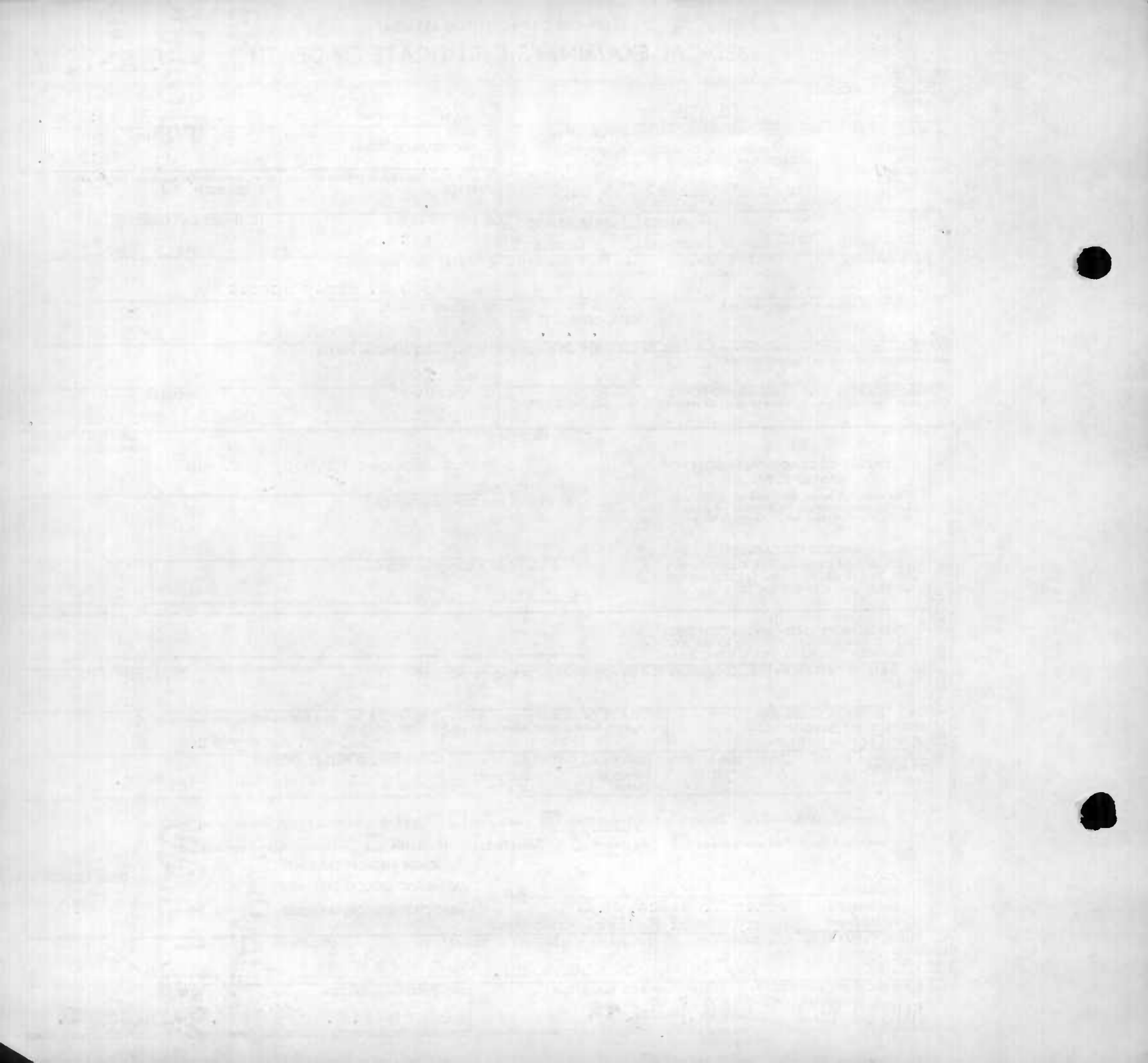
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

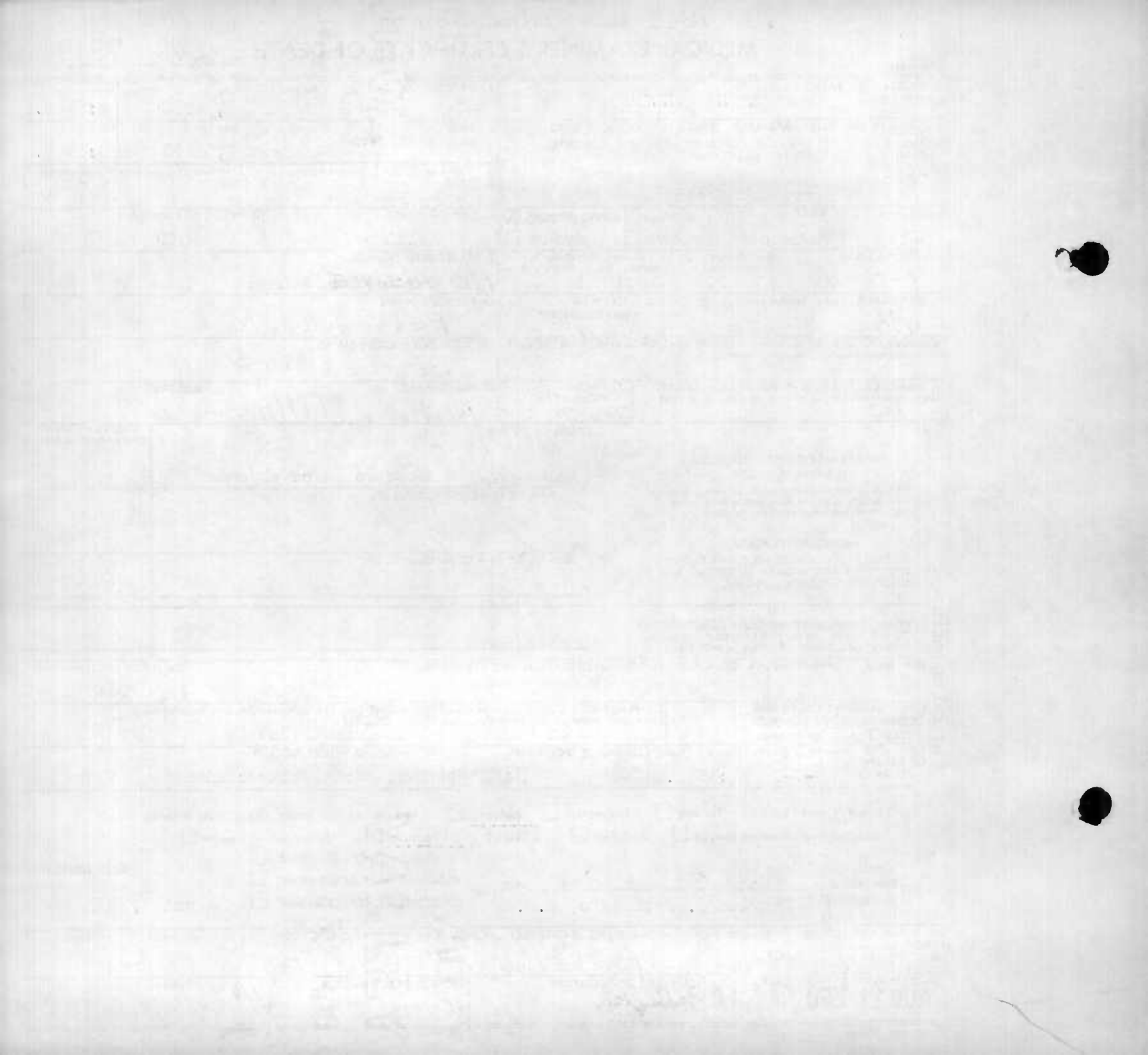
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                            |                                                                                                                                                             |                                                                                                                                          | 70 7946                                                                                                                                                                                                                                                                                                                              |                                                                             | 70 7946                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------|--|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                            |                                                                                                                                                             |                                                                                                                                          | REG. NO.                                                                                                                                                                                                                                                                                                                             |                                                                             | 70 7946                                                                            |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>RODGERS, Nicholas Thomas</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                            |                                                                                                                                                             |                                                                                                                                          | 2. DATE AND HOUR OF DEATH<br><b>9 AUGUST 1970 6:07A</b>                                                                                                                                                                                                                                                                              |                                                                             |                                                                                    |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>23 VETERANS ADMINISTRATION HOSPITAL<br/>3900 LOCH RAVEN BOULEVARD<br/>BALTIMORE, MARYLAND 21218</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |                            |                                                                                                                                                             |                                                                                                                                          | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b><br>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>1631 WESTWOOD AVENUE</b> |                                                                             |                                                                                    |  |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 6. RACE<br><b>NEGRO ID</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-10-92</b>                                                                                                       | 9. AGE (In years last birthday) <b>78</b>                                                                                                                                                                                                                                                                                            | If Under 1 Yr. Months: Days: Hours: Min.                                    |                                                                                    |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>BUTLER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                            |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                        |                                                                                                                                                                                                                                                                                                                                      | 11. BIRTHPLACE (State or foreign country)<br><b>HOWARD COUNTY, MARYLAND</b> |                                                                                    |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                            |                                                                                                                                                             | 13. FATHER'S NAME<br><b>THOMAS RODGERS</b>                                                                                               |                                                                                                                                                                                                                                                                                                                                      |                                                                             |                                                                                    |  |
| 14. MOTHER'S MAIDEN NAME<br><b>SARAH CROSS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                            |                                                                                                                                                             | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES 5-31-17 TO 3-3-19</b> |                                                                                                                                                                                                                                                                                                                                      |                                                                             |                                                                                    |  |
| 16. SOCIAL SECURITY NO.<br><b>219-30-9993</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                            |                                                                                                                                                             | 17. INFORMANT ADDRESS<br><b>VA HOSPITAL RECORDS<br/>3900 LOCH RAVEN BLVD, BALTO, MD 21218</b>                                            |                                                                                                                                                                                                                                                                                                                                      |                                                                             |                                                                                    |  |
| 18. <b>410.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(A) IMMEDIATE CAUSE<br><b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>(C) <b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                            |                                                                                                                                                             |                                                                                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                         |                                                                             |                                                                                    |  |
| 19A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                          | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>                                                                                                                                                                                                                                                                                              |                                                                             | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                            | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                          | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                                                                                                                                                                                          |                                                                             |                                                                                    |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                            | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |                                                                                                                                          | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                           |                                                                             |                                                                                    |  |
| 22. I certify that <b>(I)</b> (this hospital) attended the deceased from <b>7 JULY 1970</b> to <b>9 AUGUST 1970</b> that <b>(I)</b> (we) lost saw the deceased alive on <b>9 AUGUST 1970</b> and that <b>(I)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                                                                                                   |                            |                                                                                                                                                             |                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                      |                                                                             |                                                                                    |  |
| 23A. SIGNATURE<br><b>Marguerite T. Moran M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                            |                                                                                                                                                             |                                                                                                                                          | 23B. DATE SIGNED                                                                                                                                                                                                                                                                                                                     |                                                                             |                                                                                    |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>MARGUERITE T. MORAN MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                            |                                                                                                                                                             |                                                                                                                                          | 23D. ADDRESS<br><b>3900 LOCH RAVEN BLVD<br/>BALTIMORE, MARYLAND 21218</b>                                                                                                                                                                                                                                                            |                                                                             |                                                                                    |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                            | 24B. DATE<br><b>8-13-70</b>                                                                                                                                 |                                                                                                                                          | 24C. NAME OF CEMETERY or CREMATORY<br><b>London Pk. Nat'l. Btlo - Md.</b>                                                                                                                                                                                                                                                            |                                                                             | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>             |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>AUG 11 1970</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                            | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>                                                                                                     |                                                                                                                                          | 25C. FUNERAL DIRECTOR<br><b>KELSON FUNERAL HOME</b>                                                                                                                                                                                                                                                                                  |                                                                             | 25D. ADDRESS<br><b>1348 N. Calhoun St.<br/>Baltimore, Md.</b>                      |  |



| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                     |         | REG. NO.                                                                                                |                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------|-----------------|
| D-200                                                                                                                                                                                                                                                                                                                                                                                                         |         | 70 7947                                                                                                 |                 |
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                              |         |                                                                                                         |                 |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                       |         |                                                                                                         |                 |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                        |         | 2. DATE OF DEATH                                                                                        |                 |
| Edward Diggs                                                                                                                                                                                                                                                                                                                                                                                                  |         | Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month 8 Day 4 Year 70 Hour 4:30 a. M. |                 |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION                                                                                                                                                                                                                                                                                                                |         | 3. DATE PRONOUNCED DEAD                                                                                 |                 |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                                                          |         | Month 8 Day 4 Year 70 Hour 4:30 a. M.                                                                   |                 |
| Maryland General Hospital                                                                                                                                                                                                                                                                                                                                                                                     |         | 5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)                   |                 |
| A. STATE Md.                                                                                                                                                                                                                                                                                                                                                                                                  |         | B. COUNTY 1501                                                                                          |                 |
| 6. SEX                                                                                                                                                                                                                                                                                                                                                                                                        | 7. RACE | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                              | C. CITY OR TOWN |
| male                                                                                                                                                                                                                                                                                                                                                                                                          | Negro   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                      | Balto.          |
| 9. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                              |         | D. INSIDE CITY LIMITS?                                                                                  |                 |
| 6/10/61                                                                                                                                                                                                                                                                                                                                                                                                       |         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |                 |
| 10. AGE (In years last birthday)                                                                                                                                                                                                                                                                                                                                                                              |         | E. STREET AND NUMBER                                                                                    |                 |
| 9                                                                                                                                                                                                                                                                                                                                                                                                             |         | 1534 N. Carey Street                                                                                    |                 |
| 11. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                     |         | 12. CITIZEN OF WHAT COUNTRY?                                                                            |                 |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                      |         | U.S.A.                                                                                                  |                 |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                    |         | 13. FATHER'S NAME                                                                                       |                 |
|                                                                                                                                                                                                                                                                                                                                                                                                               |         | James Chapman                                                                                           |                 |
| 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                             |         | 15. MOTHER'S MAIDEN NAME                                                                                |                 |
|                                                                                                                                                                                                                                                                                                                                                                                                               |         | Garethia Diggs                                                                                          |                 |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                               |         | 17. SOCIAL SECURITY NO.                                                                                 |                 |
| No                                                                                                                                                                                                                                                                                                                                                                                                            |         |                                                                                                         |                 |
| 18. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                 |         | ADDRESS                                                                                                 |                 |
| Marietta Smith                                                                                                                                                                                                                                                                                                                                                                                                |         | 3902 Reistertown Rd.                                                                                    |                 |
| 19. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                            |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                            |                 |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                                                                                |         | Burns of most of body surface                                                                           |                 |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                                                                    |         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                     |                 |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                                                                             |         | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                     |                 |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                     |         | (C)                                                                                                     |                 |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                           |         |                                                                                                         |                 |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                        |         | 21. AUTOPSY? (Yes or No)                                                                                |                 |
| 0                                                                                                                                                                                                                                                                                                                                                                                                             |         | no                                                                                                      |                 |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                               |         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                |                 |
|                                                                                                                                                                                                                                                                                                                                                                                                               |         | Home                                                                                                    |                 |
| 22D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                 |         | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                |                 |
| Month 8 Day 4 Year 70 ?                                                                                                                                                                                                                                                                                                                                                                                       |         | 1534 N. Carey St. 1501                                                                                  |                 |
| 22E. INJURY OCCURRED.                                                                                                                                                                                                                                                                                                                                                                                         |         | 22F. HOW DID INJURY OCCUR?                                                                              |                 |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                  |         | Subject burned in house fire.                                                                           |                 |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                                                                                                         |                 |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                              |         | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                         |                 |
| EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                        |         | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                                     |                 |
| Werner U. Spitz, M.D.                                                                                                                                                                                                                                                                                                                                                                                         |         | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>                                                     |                 |
| Deputy Chief Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                 |         | DATE SIGNED 8/4/70                                                                                      |                 |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                      |         | 24B. DATE                                                                                               |                 |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                        |         | 8/10/70                                                                                                 |                 |
| 24C. NAME OF CEMETERY or CREMATORY                                                                                                                                                                                                                                                                                                                                                                            |         | 24D. LOCATION (City, town, or county) (State)                                                           |                 |
| Arbutus Mem. Park                                                                                                                                                                                                                                                                                                                                                                                             |         | Baltimore, Maryland                                                                                     |                 |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                                                                                               |         | 25B. NAME OF REGISTRAR                                                                                  |                 |
| AUG 11 1970                                                                                                                                                                                                                                                                                                                                                                                                   |         | Robert E. Farber, M.D.                                                                                  |                 |
| 25C. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                         |         | ADDRESS                                                                                                 |                 |
| Kelson, F.H.                                                                                                                                                                                                                                                                                                                                                                                                  |         | 1348 N. Calhoun St.                                                                                     |                 |



| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                     |  | REG. NO.                                                                                    |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| M-452                                                                                                                                                                                                                                                                                                                                                                                                         |  | 70 7948                                                                                     |  |
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                             |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                        |  | 2. DATE OF DEATH                                                                            |  |
| LEON MULLINS                                                                                                                                                                                                                                                                                                                                                                                                  |  | Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> August 7, 1970 |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION                                                                                                                                                                                                                                                                                                                |  | 3. DATE PRONOUNCED DEAD                                                                     |  |
| 39 Provident Hospital                                                                                                                                                                                                                                                                                                                                                                                         |  | Month Day Year August 7, 1970                                                               |  |
| 6. SEX                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)       |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                          |  | A. STATE Maryland                                                                           |  |
| 7. RACE                                                                                                                                                                                                                                                                                                                                                                                                       |  | B. COUNTY                                                                                   |  |
| Negro                                                                                                                                                                                                                                                                                                                                                                                                         |  | 1402                                                                                        |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                         |  | C. CITY OR TOWN                                                                             |  |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                            |  | Baltimore                                                                                   |  |
| 9. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                              |  | D. INSIDE CITY LIMITS?                                                                      |  |
| 1-9-40                                                                                                                                                                                                                                                                                                                                                                                                        |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |  |
| 10. AGE (In years last birthday)                                                                                                                                                                                                                                                                                                                                                                              |  | E. STREET AND NUMBER                                                                        |  |
| 30                                                                                                                                                                                                                                                                                                                                                                                                            |  | 1112 ARGYLE Avenue                                                                          |  |
| 11. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                     |  | 12. CITIZEN OF WHAT COUNTRY?                                                                |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                           |  | U.S.A.                                                                                      |  |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                             |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |
| FRED WILSON                                                                                                                                                                                                                                                                                                                                                                                                   |  | 14b. KIND OF BUSINESS OR INDUSTRY                                                           |  |
| BESSIE BRYANT                                                                                                                                                                                                                                                                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME                                                                    |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                       |  | 17. SOCIAL SECURITY NO.                                                                     |  |
| NO                                                                                                                                                                                                                                                                                                                                                                                                            |  | 213-366081                                                                                  |  |
| 18. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                 |  | ADDRESS                                                                                     |  |
| Norman Mullins                                                                                                                                                                                                                                                                                                                                                                                                |  | N.Y.                                                                                        |  |
| 19. CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                                  |  | (A) IMMEDIATE CAUSE                                                                         |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                |  | Gunshot wound of abdomen<br>DUE TO, OR AS A CONSEQUENCE OF:                                 |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                              |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                               |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                         |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                        |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                            |  |
| 2                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                             |  |
| 21. AUTOPSY? (Yes or No)                                                                                                                                                                                                                                                                                                                                                                                      |  | Yes                                                                                         |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                               |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                               |  | steps of house                                                                              |  |
| 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                      |  | 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)                                   |  |
| 1918 Eutaw Place                                                                                                                                                                                                                                                                                                                                                                                              |  | 8-7-70 7:15 P.m.                                                                            |  |
| 22E. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                          |  | 22F. HOW DID INJURY OCCUR?                                                                  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                  |  | Shot during altercation                                                                     |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                             |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                              |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                             |  |
| EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                        |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                              |  |
| Charles S. Springate, M.D.                                                                                                                                                                                                                                                                                                                                                                                    |  | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>                                         |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                      |  | 24B. DATE                                                                                   |  |
| Balto.                                                                                                                                                                                                                                                                                                                                                                                                        |  | 8-12-70                                                                                     |  |
| 24C. NAME OF CEMETERY or CREMATORY                                                                                                                                                                                                                                                                                                                                                                            |  | 24D. LOCATION (City, town, or county) (State)                                               |  |
| Mt. Auburn Cem.                                                                                                                                                                                                                                                                                                                                                                                               |  | Balto., Md.                                                                                 |  |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                                                                                                                                                                                                                                                                                               |  | 25B. NAME OF REGISTRAR                                                                      |  |
| AUG 11 1970                                                                                                                                                                                                                                                                                                                                                                                                   |  | Robert E. Taylor, R.D.                                                                      |  |
| 25C. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                         |  | ADDRESS                                                                                     |  |
| V. BAILEY                                                                                                                                                                                                                                                                                                                                                                                                     |  | KELSON F.H. 1348 CALHOUN ST.                                                                |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

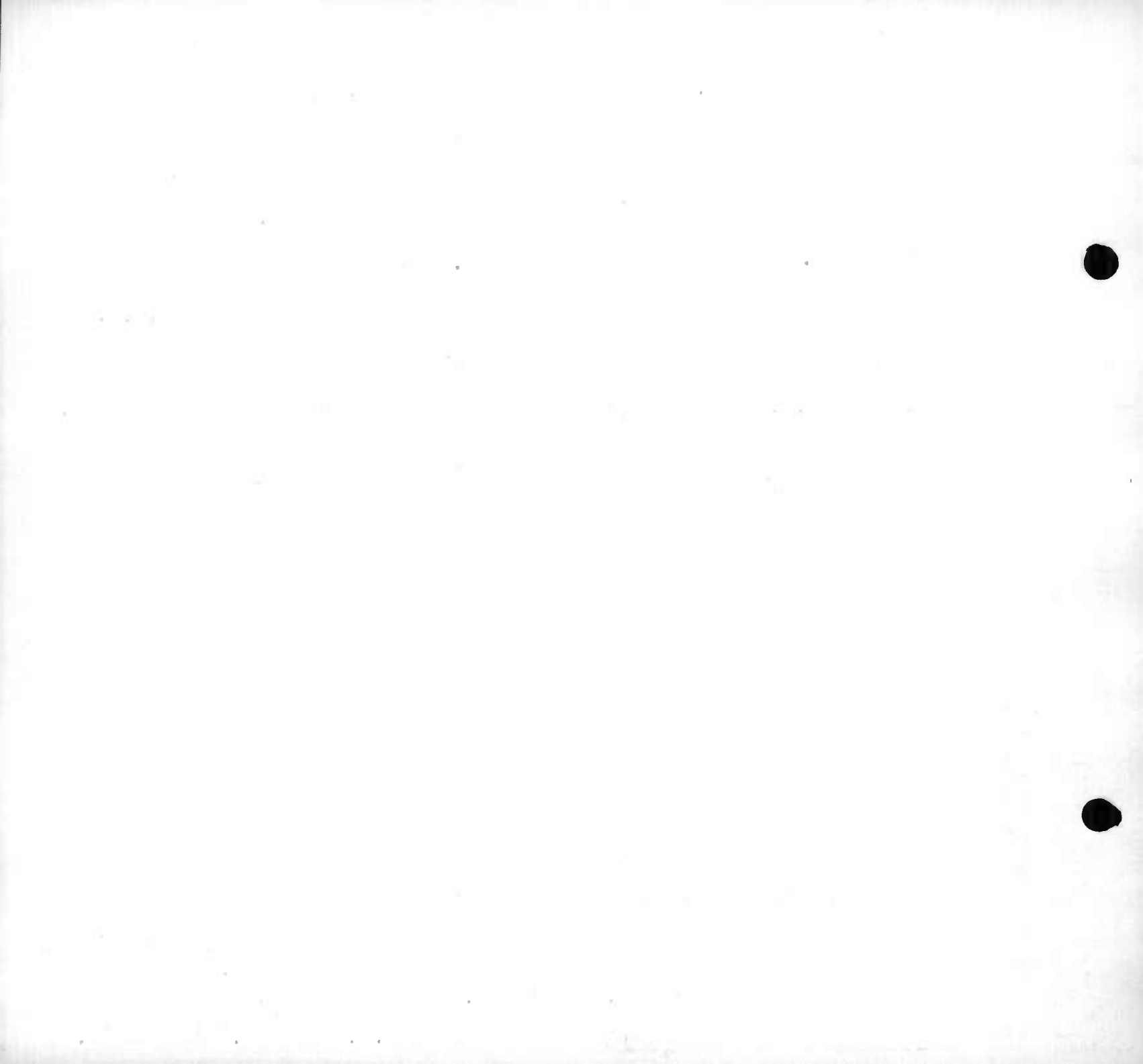
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                       |         |                                                                                          |                  | REG. NO. 70 7949                                                         |                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|--------------------------------|
| P-200 70 7949                                                                                                                                                                                                                                                                                                          |         | BIRTH NO.                                                                                |                  |                                                                          |                                |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                 |         | 2. DATE AND HOUR OF DEATH                                                                |                  |                                                                          |                                |
| Mr. James Pace                                                                                                                                                                                                                                                                                                         |         | August 8, 1970 7:30 A.M.                                                                 |                  |                                                                          |                                |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                 |         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)    |                  |                                                                          |                                |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                              |         | A. STATE B. COUNTY                                                                       |                  |                                                                          |                                |
| 39 PROVIDENT HOSPITAL                                                                                                                                                                                                                                                                                                  |         | Maryland 1703                                                                            |                  |                                                                          |                                |
|                                                                                                                                                                                                                                                                                                                        |         | C. CITY OR TOWN                                                                          |                  | D. INSIDE CITY LIMITS?                                                   |                                |
|                                                                                                                                                                                                                                                                                                                        |         | Baltimore                                                                                |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |                                |
|                                                                                                                                                                                                                                                                                                                        |         | E. STREET AND NUMBER                                                                     |                  |                                                                          |                                |
|                                                                                                                                                                                                                                                                                                                        |         | 1058 Arglye Avenue                                                                       |                  |                                                                          |                                |
| 5. SEX                                                                                                                                                                                                                                                                                                                 | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>    | 8. DATE OF BIRTH | 9. AGE (In years last birthday)                                          | 10. If Under 1 Yr. Months Days |
| Male                                                                                                                                                                                                                                                                                                                   | Negro   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | 2-7-98           | 72                                                                       |                                |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                            |         | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |                  | 11. BIRTHPLACE (State or foreign country)                                |                                |
| Elkes Home                                                                                                                                                                                                                                                                                                             |         | Unknown                                                                                  |                  | WEST INDIES Va.                                                          |                                |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                      |         | 14. MOTHER'S MAIDEN NAME                                                                 |                  | 12. CITIZEN OF WHAT COUNTRY?                                             |                                |
|                                                                                                                                                                                                                                                                                                                        |         |                                                                                          |                  | U.S.A.                                                                   |                                |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                               |         | 16. SOCIAL SECURITY NO.                                                                  |                  | 17. INFORMANT ADDRESS                                                    |                                |
| no                                                                                                                                                                                                                                                                                                                     |         |                                                                                          |                  | Miss Michelle Johnson 3110 Reisterstown Rd.                              |                                |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                     |         | CAUSE OF DEATH                                                                           |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |                                |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                           |         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                      |                  |                                                                          |                                |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                      |         | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                      |                  |                                                                          |                                |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                              |         | (C) Arteriosclerotic Heart Disease                                                       |                  |                                                                          |                                |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                       |         |                                                                                          |                  |                                                                          |                                |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                 |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |                  | 20A. AUTOPSY? (Yes or No)                                                |                                |
| 0                                                                                                                                                                                                                                                                                                                      |         |                                                                                          |                  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?     |                                |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                  |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                |
| 21D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                          |         | 21E. INJURY OCCURRED                                                                     |                  | 21F. HOW DID INJURY OCCUR?                                               |                                |
| (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                            |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                  |                                                                          |                                |
| 22. I certify that (I) (this hospital) attended the deceased from July 13, 1970 to August 8, 1970 that (I) (we) last saw the deceased alive on August 8, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |                                                                                          |                  |                                                                          |                                |
| 23A. SIGNATURE                                                                                                                                                                                                                                                                                                         |         | 23B. DATE SIGNED                                                                         |                  |                                                                          |                                |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                           |         | 23D. ADDRESS                                                                             |                  |                                                                          |                                |
| Dr. Loot5                                                                                                                                                                                                                                                                                                              |         | PROVIDENT HOSPITAL 1514 Division St.                                                     |                  |                                                                          |                                |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                               |         | 24B. DATE                                                                                |                  | 24C. NAME OF CEMETERY or CREMATORY                                       |                                |
| Burial                                                                                                                                                                                                                                                                                                                 |         | 8-12-70                                                                                  |                  | Mt. Auburn Cemetery                                                      |                                |
|                                                                                                                                                                                                                                                                                                                        |         |                                                                                          |                  | Balto., Md.                                                              |                                |
| 25A. DATE RECEIVED IN HEALTH DEPT.                                                                                                                                                                                                                                                                                     |         | 25B. NAME OF REGISTRAR                                                                   |                  | 25C. FUNERAL DIRECTOR                                                    |                                |
| AUG 11 1970                                                                                                                                                                                                                                                                                                            |         | V. Bailey                                                                                |                  | Kelson F.H. 1348 Calhoun St.                                             |                                |

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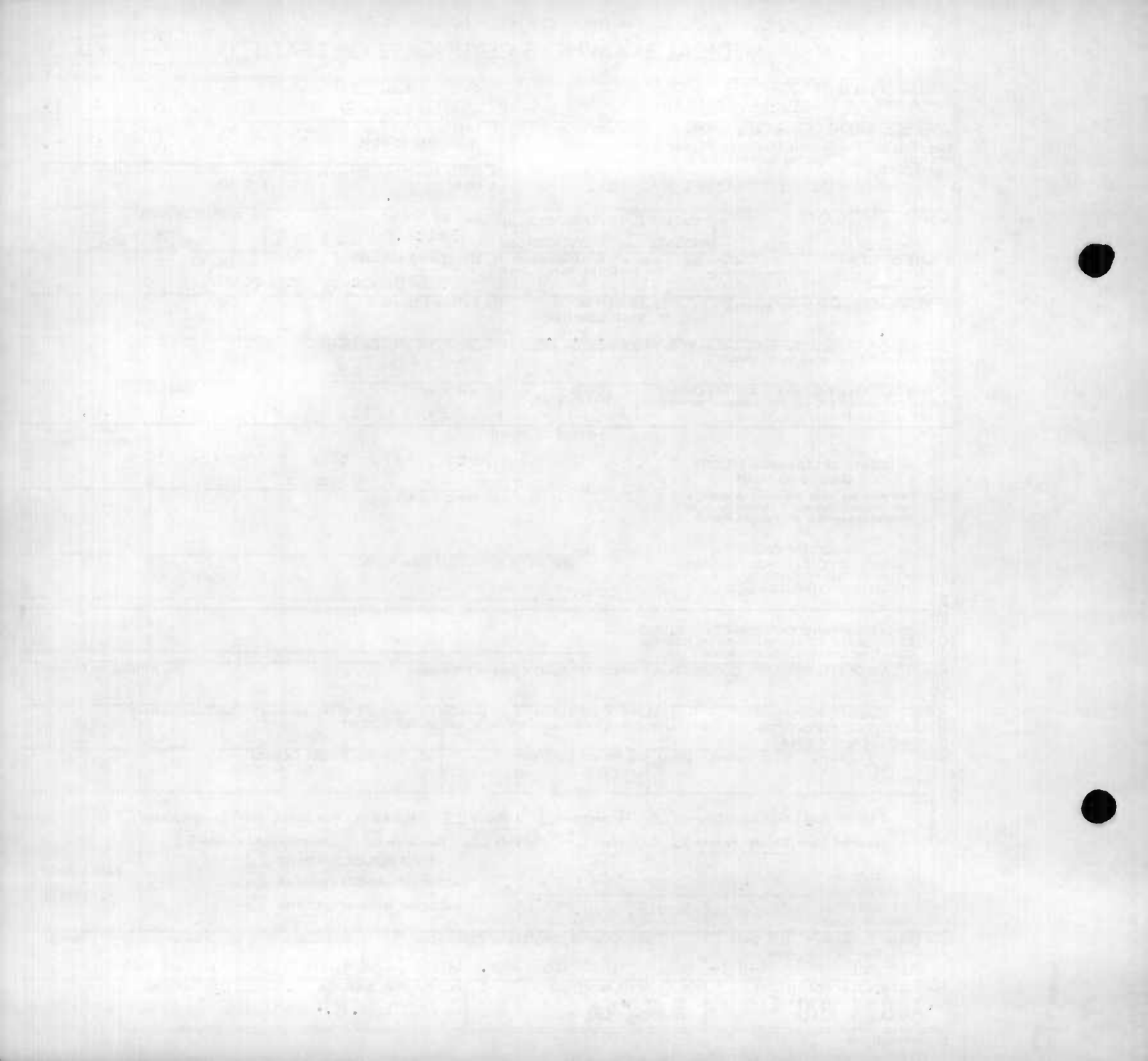
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                            |         |                                                                                          |                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|-----------------------------------------------------|
| P-626 70 7950                                                                                                                              |         | BALTIMORE CITY HEALTH DEPARTMENT                                                         |                                                     |
| BIRTH NO.                                                                                                                                  |         | CERTIFICATE OF DEATH                                                                     |                                                     |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                     |         | 2. DATE AND HOUR OF DEATH                                                                |                                                     |
| Douglas I. Parker                                                                                                                          |         | Aug. 5, 1970                                                                             |                                                     |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                     |         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)    |                                                     |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                  |         | A. STATE B. COUNTY                                                                       |                                                     |
| 00 726 Whitmore Ave.                                                                                                                       |         | Maryland 1605                                                                            |                                                     |
| 5. CITY OR TOWN                                                                                                                            |         | D. INSIDE CITY LIMITS?                                                                   |                                                     |
| Baltimore                                                                                                                                  |         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |                                                     |
| E. STREET AND NUMBER                                                                                                                       |         | 726 Whitmore Ave.                                                                        |                                                     |
| 5. SEX                                                                                                                                     | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    | 8. DATE OF BIRTH                                    |
| Male                                                                                                                                       | Negro   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | Mar. 12, 1918                                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                |         | 10B. KIND OF BUSINESS OR INDUSTRY                                                        |                                                     |
| Projectioness                                                                                                                              |         | 11. BIRTHPLACE (State or foreign country)                                                |                                                     |
| 13. FATHER'S NAME                                                                                                                          |         | 12. CITIZEN OF WHAT COUNTRY?                                                             |                                                     |
| George Parker                                                                                                                              |         | U.S.A.                                                                                   |                                                     |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                   |         | 16. SOCIAL SECURITY NO.                                                                  |                                                     |
| Yes W.W. II                                                                                                                                |         | 215-03-3048                                                                              |                                                     |
| 17. INFORMANT                                                                                                                              |         | ADDRESS                                                                                  |                                                     |
| Bernice Parker                                                                                                                             |         | 726 Whitmore Ave.                                                                        |                                                     |
| 18. CAUSE OF DEATH                                                                                                                         |         |                                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                                                                                             |         |                                                                                          | A - S. H. D.                                        |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) |         |                                                                                          | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: |
| ANTECEDENT CAUSES                                                                                                                          |         |                                                                                          | (B) DUE TO, OR AS A CONSEQUENCE OF:                 |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                  |         |                                                                                          | (C) DUE TO, OR AS A CONSEQUENCE OF:                 |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).        |         |                                                                                          |                                                     |
| 19A. DATE OF OPERATION                                                                                                                     |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                         |                                                     |
| 0                                                                                                                                          |         | 20A. AUTOPSY? (Yes or No)                                                                |                                                     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                      |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                                                     |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                   |         | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)                                          |                                                     |
| 21E. INJURY OCCURRED                                                                                                                       |         | 21F. HOW DID INJURY OCCUR?                                                               |                                                     |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                          |         | 22. I certify that (I) (this hospital) attended the deceased from 11-26-1969 to 8-5-1970 |                                                     |
| 23A. SIGNATURE                                                                                                                             |         | 23B. DATE SIGNED                                                                         |                                                     |
| BARBU CALIN                                                                                                                                |         | 8-8-70                                                                                   |                                                     |
| 23C. PHYSICIAN'S NAME (Type)                                                                                                               |         | 23D. ADDRESS                                                                             |                                                     |
| BARBU CALIN                                                                                                                                |         | 831 Paylor Grove                                                                         |                                                     |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                   |         | 24B. DATE                                                                                |                                                     |
| Burial                                                                                                                                     |         | 8/10/70                                                                                  |                                                     |
| 24C. NAME of CEMETERY or CREMATORY                                                                                                         |         | 24D. LOCATION (City, town, or county) (State)                                            |                                                     |
| Balto. Nat'l Cem.                                                                                                                          |         | Baltimore, Maryland                                                                      |                                                     |
| 25A. DATE REC'D BY HEALTH DEPT.                                                                                                            |         | 25B. NAME OF REGISTRAR                                                                   |                                                     |
| AUG 11 1970                                                                                                                                |         | Kelson F.H.                                                                              |                                                     |
| 25C. FUNERAL DIRECTOR                                                                                                                      |         | ADDRESS                                                                                  |                                                     |
| V.R. Bailey                                                                                                                                |         | 1348 N. Calhoun St.                                                                      |                                                     |



| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                        |                                                  |                                                                                                                                                             |                                                                                                                    |                                                                             |                               |                                                                                               |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------|-----------------------------------------------------------------------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                        |                                                  |                                                                                                                                                             |                                                                                                                    |                                                                             |                               |                                                                                               |  |
| REG. NO. 70 7951                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                        |                                                  |                                                                                                                                                             |                                                                                                                    |                                                                             |                               |                                                                                               |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                        |                                                  |                                                                                                                                                             |                                                                                                                    |                                                                             |                               |                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print) Arthur Willis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                        |                                                  |                                                                                                                                                             | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> 8 9 70 6:58 p. M. |                                                                             |                               |                                                                                               |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>Union Memorial Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                        |                                                  |                                                                                                                                                             | 3. DATE PRONOUNCED DEAD<br>Month 8 Day 9 Year 70 6:58 p. M.                                                        |                                                                             |                               |                                                                                               |  |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md. B. COUNTY 2037                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                        |                                                  |                                                                                                                                                             |                                                                                                                    |                                                                             |                               |                                                                                               |  |
| 6. SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 7. RACE<br>Negro                       |                                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                    | C. CITY OR TOWN<br>Balto.                                                   |                               | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br>4-27-13                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10. AGE (In years last birthday)<br>57 |                                                  | 11. BIRTHPLACE (State or foreign country)<br>Va.                                                                                                            |                                                                                                                    | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                      |                               | E. STREET AND NUMBER<br>315 Grantley Street                                                   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                        |                                                  |                                                                                                                                                             | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                  |                                                                             |                               |                                                                                               |  |
| 15. MOTHER'S MAIDEN NAME<br>Ida Willis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                        |                                                  |                                                                                                                                                             |                                                                                                                    |                                                                             |                               |                                                                                               |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                        |                                                  |                                                                                                                                                             | 17. SOCIAL SECURITY NO.<br>227121172                                                                               |                                                                             | 18. INFORMANT<br>Emily Willis |                                                                                               |  |
| 19. 4124<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>Arteriosclerotic cardiovascular disease<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                              |  |                                        |                                                  |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                       |                                                                             |                               |                                                                                               |  |
| 20A. DATE OF OPERATION<br>2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                        |                                                  |                                                                                                                                                             | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                   |                                                                             |                               |                                                                                               |  |
| 21. AUTOPSY? (Yes or No)<br>yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                        |                                                  |                                                                                                                                                             |                                                                                                                    |                                                                             |                               |                                                                                               |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                        |                                                  |                                                                                                                                                             | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                           |                                                                             |                               |                                                                                               |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                        |                                                  |                                                                                                                                                             |                                                                                                                    |                                                                             |                               |                                                                                               |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                        |                                                  |                                                                                                                                                             | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>          |                                                                             |                               |                                                                                               |  |
| 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                        |                                                  |                                                                                                                                                             |                                                                                                                    |                                                                             |                               |                                                                                               |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8/10/70 |  |                                        |                                                  |                                                                                                                                                             |                                                                                                                    |                                                                             |                               |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                        | 24B. DATE<br>8-13-70                             |                                                                                                                                                             | 24C. NAME OF CEMETERY or CREMATORY<br>Arbutus Mem. Park                                                            |                                                                             |                               | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland                          |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>AUG 11 1970                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                        | 25B. NAME OF REGISTRAR<br>Robert E. Farley, M.D. |                                                                                                                                                             |                                                                                                                    | 25C. FUNERAL DIRECTOR V. Bailey ADDRESS<br>Kelson, F.H. 1348 Calhoun Street |                               |                                                                                               |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                      |  |                                                                                                                     |  | REG. NO. 70 7952                                                                                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO. J-525 70 7952                                                                                                                                                                                                                                                                               |  | CERTIFICATE OF DEATH                                                                                                |  |                                                                                                                                                          |  |
| 1. NAME OF DECEASED (Type or Print) GRACE Johnson                                                                                                                                                                                                                                                     |  | 2. DATE AND HOUR OF DEATH 8/9/70 8:15 A.M.                                                                          |  |                                                                                                                                                          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Balto. |  |                                                                                                                                                          |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital 601 N. Broadway, Balto. Md.                                                                                                                                       |  | C. CITY OR TOWN Baltimore City                                                                                      |  | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                               |  |
| 5. SEX F                                                                                                                                                                                                                                                                                              |  | 6. RACE N                                                                                                           |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH 12/4/98                                                                                                                                                                                                                                                                              |  | 9. AGE (In years last birthday) 71                                                                                  |  | 10. UNDER 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                                                                               |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                           |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                   |  | 11. BIRTHPLACE (State or foreign country) Md.                                                                                                            |  |
| 12. CITIZEN OF WHAT COUNTRY U.S.A.                                                                                                                                                                                                                                                                    |  | 13. FATHER'S NAME John Hicks                                                                                        |  | 14. MOTHER'S MAIDEN NAME Martha Buchanan                                                                                                                 |  |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no                                                                                                                                                                                           |  | 16. SOCIAL SECURITY NO. 219183570                                                                                   |  | 17. INFORMANT Emeline Boston ADDRESS same                                                                                                                |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)                                                                                                         |  | CAUSE OF DEATH                                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |  |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                     |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Arrest                                              |  |                                                                                                                                                          |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                             |  | (B) Cardiac arrhythmias                                                                                             |  |                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                       |  | (C)                                                                                                                 |  |                                                                                                                                                          |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                   |  | Possible tumor in belly                                                                                             |  |                                                                                                                                                          |  |
| 19A. DATE OF OPERATION 2                                                                                                                                                                                                                                                                              |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                    |  | 20A. AUTOPSY? (Yes or No) Yes                                                                                                                            |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                        |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                            |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) not performed yet                                                               |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                             |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>              |  | 21F. HOW DID INJURY OCCUR?                                                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from 8/3 1970 to 8/9 1970 that (I) (we) lost saw the deceased alive on 8/9 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                                     |  |                                                                                                                                                          |  |
| 23A. SIGNATURE Peter Densen MD                                                                                                                                                                                                                                                                        |  | 23B. DATE SIGNED 8/9/70                                                                                             |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>                                     |  |
| 23C. PHYSICIAN'S NAME (Type) Peter Densen MD                                                                                                                                                                                                                                                          |  | 23D. ADDRESS 601 N. Broadway Balto. Md.                                                                             |  |                                                                                                                                                          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                       |  | 24B. DATE 8-13-70                                                                                                   |  | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery                                                                                                   |  |
| 24D. LOCATION Baltimore, Maryland                                                                                                                                                                                                                                                                     |  | 25A. DATE REC'D BY HEALTH DEPT. AUG 11 1970                                                                         |  |                                                                                                                                                          |  |
| 25B. NAME OF REGISTRAR Robert E. Bailey Jr.                                                                                                                                                                                                                                                           |  | 25C. FUNERAL DIRECTOR V. Bailey ADDRESS Kelson F.H. 1348 Calhoun Street                                             |  |                                                                                                                                                          |  |



P-620<sup>1</sup>

70 7953

BALTIMORE CITY HEALTH DEPARTMENT

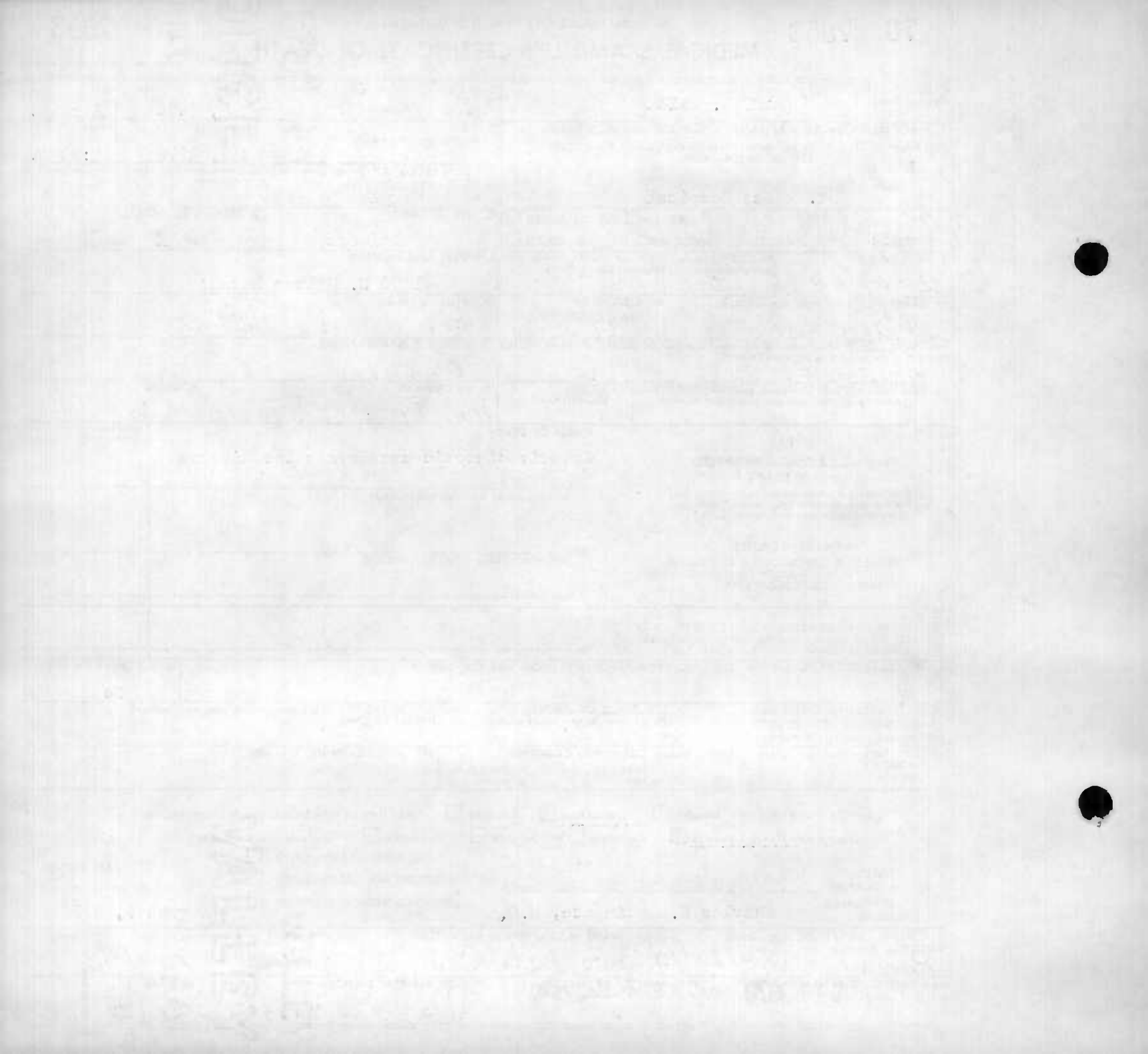
70 7953

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) MARY B. PRICE                                                                                                                                                                                                                                                                                                                                                          |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> August 8, 1970 11:34 A.M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>40 St. Agnes Hospital                                                                                                                                                                                                                  |  | 3. DATE PRONOUNCED DEAD<br>August 8, 1970 11:34 A.M.                                                                       |  |
| 6. SEX Female                                                                                                                                                                                                                                                                                                                                                                                                 |  | 7. RACE Negro                                                                                                              |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                 |  | C. CITY OR TOWN Baltimore                                                                                                  |  |
| 9. DATE OF BIRTH 2-19-90                                                                                                                                                                                                                                                                                                                                                                                      |  | 10. AGE (In years lost birthday) 80                                                                                        |  |
| 11. BIRTHPLACE (State or foreign country) Maryland                                                                                                                                                                                                                                                                                                                                                            |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                        |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife                                                                                                                                                                                                                                                                                                         |  | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                       |  | 17. SOCIAL SECURITY NO.                                                                                                    |  |
| 18. INFORMANT Mrs. Frances Sigale                                                                                                                                                                                                                                                                                                                                                                             |  | ADDRESS 18. N. H. Henshaw                                                                                                  |  |
| 19. 4124 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Arteriosclerotic cardiovascular disease                                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                           |  |                                                                                                                            |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                        |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                           |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                          |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                   |  |
| 22D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                 |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                     |  |
| 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                            |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                            |  |
| ACTUAL SIGNATURE Charles E. Springate, M.D.                                                                                                                                                                                                                                                                                                                                                                   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                            |  |
| EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                        |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                               |  | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>                                                                        |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                                                                                               |  | 24B. DATE 8-12-70                                                                                                          |  |
| 24C. NAME OF CEMETERY or CREMATORY Balto. Nat. Cem                                                                                                                                                                                                                                                                                                                                                            |  | 24D. LOCATION (City, town, or county) (State) Baltimore Md                                                                 |  |
| 25A. DATE RECEIVED BY HEALTH DEPT. AUG 11 1970                                                                                                                                                                                                                                                                                                                                                                |  | 25B. NAME OF REGISTRAR Robert E. Gable, M.D.                                                                               |  |
| 25C. FUNERAL DIRECTOR Joseph L. Russ                                                                                                                                                                                                                                                                                                                                                                          |  | ADDRESS 2222 W. North Ave                                                                                                  |  |



G-435

70 7954 BALTIMORE CITY HEALTH DEPARTMENT

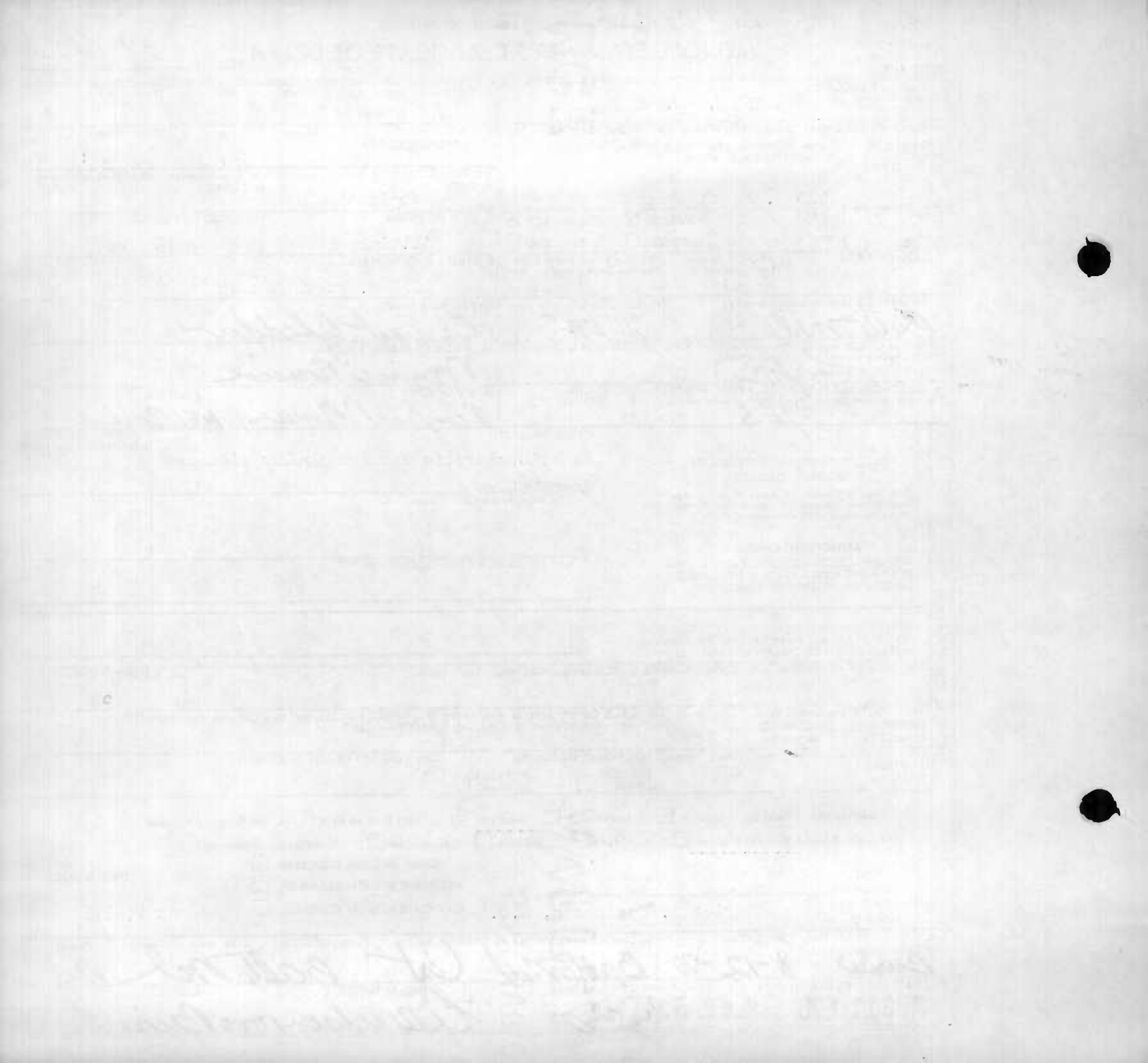
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 7954

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) DANIEL GLADDEN                                                                                                                                                                                                                                                                                                                                                         |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.                                                                               |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>1335 E. North Avenue                                                                                                                                                                                                                                  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>August ;8, 1970 10:10 A.M.                                                                                                                  |  |
| 6. SEX Male                                                                                                                                                                                                                                                                                                                                                                                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                      |  |
| 7. RACE Negro                                                                                                                                                                                                                                                                                                                                                                                                 |  | C. CITY OR TOWN Baltimore                                                                                                                                                                     |  |
| 9. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                                                                              |  | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                    |  |
| 10. AGE (In years last birthday) 45                                                                                                                                                                                                                                                                                                                                                                           |  | E. STREET AND NUMBER 1335 E. North Avenue                                                                                                                                                     |  |
| 11. BIRTHPLACE (State or foreign country) Baltimore                                                                                                                                                                                                                                                                                                                                                           |  | 13. FATHER'S NAME Ernest Gladden                                                                                                                                                              |  |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer                                                                                                                                                                                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME Frances Busio                                                                                                                                                        |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES                                                                                                                                                                                                                                                                                                   |  | 17. SOCIAL SECURITY NO.                                                                                                                                                                       |  |
| 18. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                 |  | ADDRESS Phyllis Blum - 1841 E. 3rd St                                                                                                                                                         |  |
| 19. 412.4 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Arteriosclerotic cardiovascular disease                                                                                                                                                      |  | CAUSE OF DEATH<br>Arteriosclerotic cardiovascular disease                                                                                                                                     |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                               |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                               |  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                           |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                               |  |
| 20A. DATE OF OPERATION 2                                                                                                                                                                                                                                                                                                                                                                                      |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                              |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                          |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                      |  |
| 22D. TIME OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                 |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                        |  |
| 22F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                    |  | 21. AUTOPSY? (Yes or No) Yes                                                                                                                                                                  |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                                                                                                                               |  |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.                                                                                                                                                                                                                                                                                                                                            |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 9, 1970 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                                                                                               |  | 24B. DATE 8-12-70                                                                                                                                                                             |  |
| 24C. NAME OF CEMETERY or CREMATORY Baltimore Cat                                                                                                                                                                                                                                                                                                                                                              |  | 24D. LOCATION (City, town, or county) (State) Baltimore Md                                                                                                                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 11 1970                                                                                                                                                                                                                                                                                                                                                                   |  | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D.                                                                                                                                                 |  |
| 25C. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                         |  | ADDRESS C. Wilson 1000 Bessie Ave                                                                                                                                                             |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| T-300                                                                                                                                                                                                                                                                                                                                               |                         | 70 7955                                                                                                                                                     |                                     | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                           |                            | REG. NO. 70 7955                                                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                     | 1. NAME OF DECEASED<br>(Type or Print) <b>ROBERT TATE</b>                                                                                  |                            |                                                                                               |  |
| 2. DATE AND HOUR OF DEATH<br><b>08-09-70</b>                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                     | 3:00 A. M.                                                                                                                                 |                            |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                     | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>1204</b> |                            |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>THE JOHNS HOPKINS HOSPITAL</b><br><b>33 BALTIMORE, MD 21205</b>                                                                                                                                                                     |                         |                                                                                                                                                             |                                     | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                        |                            | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| E. STREET AND NUMBER<br><b>2338 BARCLAY STREET</b>                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                     |                                                                                                                                            |                            |                                                                                               |  |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                               | 6. RACE<br><b>NEGRO</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>02-27-07</b> | 9. AGE (In years last birthday)<br><b>63</b>                                                                                               | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.                                                                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                                                                                                         |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Georgia</b>                                                                                |                            | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                    |  |
| 13. FATHER'S NAME<br><b>RAY TATE</b>                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             |                                     | 14. MOTHER'S MAIDEN NAME<br><b>WILLIE Bell</b>                                                                                             |                            |                                                                                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES</b>                                                                                                                                                                                                                              |                         | 16. SOCIAL SECURITY NO.<br><b>239-18-0915</b>                                                                                                               |                                     | 17. INFORMANT<br><b>Charlotte Tate 1211 2531 Barclay St</b>                                                                                |                            |                                                                                               |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Cancer of pancreas</b>                                                                                                                     |                         | CAUSE OF DEATH<br><b>Cancer of pancreas</b>                                                                                                                 |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b>                                                                            |                            |                                                                                               |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                      |                         | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                      |                                     |                                                                                                                                            |                            |                                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                     |                         | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                         |                                     |                                                                                                                                            |                            |                                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                     |                         | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                         |                                     |                                                                                                                                            |                            |                                                                                               |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                     |                                                                                                                                            |                            |                                                                                               |  |
| 19A. DATE OF OPERATION<br><b>6-19-70</b>                                                                                                                                                                                                                                                                                                            |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cancer of pancreas</b>                                                                               |                                     | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>                                                                                                    |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>no</b>             |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>—</b>                                                        |                                     | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)<br><b>—</b>                                                    |                            |                                                                                               |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)<br><b>—</b>                                                                                                                                                                                                                                                                            |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                     | 21F. HOW DID INJURY OCCUR?<br><b>—</b>                                                                                                     |                            |                                                                                               |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>5-13</b> 19 <b>70</b> to <b>8-9</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>8-9</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                     |                                                                                                                                            |                            |                                                                                               |  |
| 23A. SIGNATURE<br><b>Wayne B. Leadbetter M.D.</b>                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                     | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>            |                            | 23B. DATE SIGNED<br><b>8-9-70</b>                                                             |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>WAYNE B. LEADBETTER M.D.</b>                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                     | 23D. ADDRESS<br><b>21531 E MONMOUTH ST</b>                                                                                                 |                            |                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                           |                         | 24B. DATE<br><b>8-13-70</b>                                                                                                                                 |                                     | 24C. NAME OF CEMETERY or CREMATORY<br><b>Mt Airy Cent</b>                                                                                  |                            | 24D. LOCATION (City, town, or county) (State)<br><b>Balto Md</b>                              |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>AUG 11 1970</b>                                                                                                                                                                                                                                                                                               |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor M.D.</b>                                                                                                      |                                     | 25C. FUNERAL DIRECTOR<br><b>Robert E. Taylor M.D.</b>                                                                                      |                            |                                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                     | ADDRESS<br><b>1000 Bunting Ave</b>                                                                                                         |                            |                                                                                               |  |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

7956

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Thadius Williams

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☒Month  
Day  
Year8  
4  
70

Year

Hour  
10:59 a.m.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1400 E. Balto. St.

3. DATE  
PRONOUNCED DEADMonth  
Day  
Year8  
4  
70

Year

Hour  
10:59 a.m.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

301

6. SEX

male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Sept. 11, 1898

10. AGE (In years  
lost birthday)

72

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1400 E. Balto. Street

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

15. MOTHER'S MAIDEN NAME

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

unemployed

14B. KIND OF BUSINESS OR INDUSTRY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL  
SECURITY NO.

217-03-71614

18. INFORMANT

ADDRESS

Mistral Delusor

19. 412.4

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type)

Werner U. Spitz, M.D.  
Deputy Chief Medical ExaminerCHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/4/70

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8-6-70

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem.

24D. LOCATION (City, town, or county)

Baltimore

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 11 1970

25B. NAME OF REGISTRAR

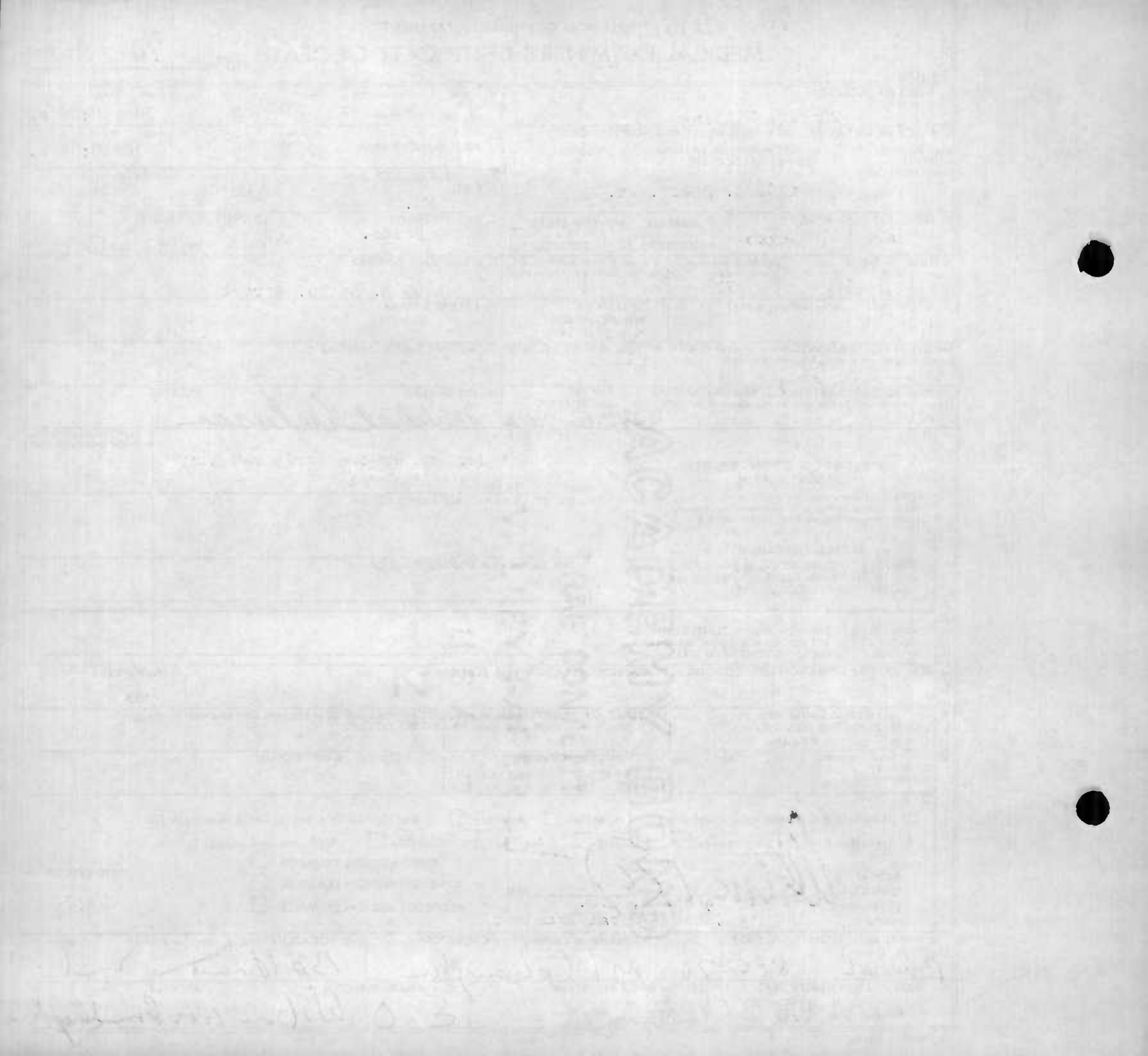
Robert E. Fisher

25C. FUNERAL DIRECTOR

E. O. Wilson

ADDRESS

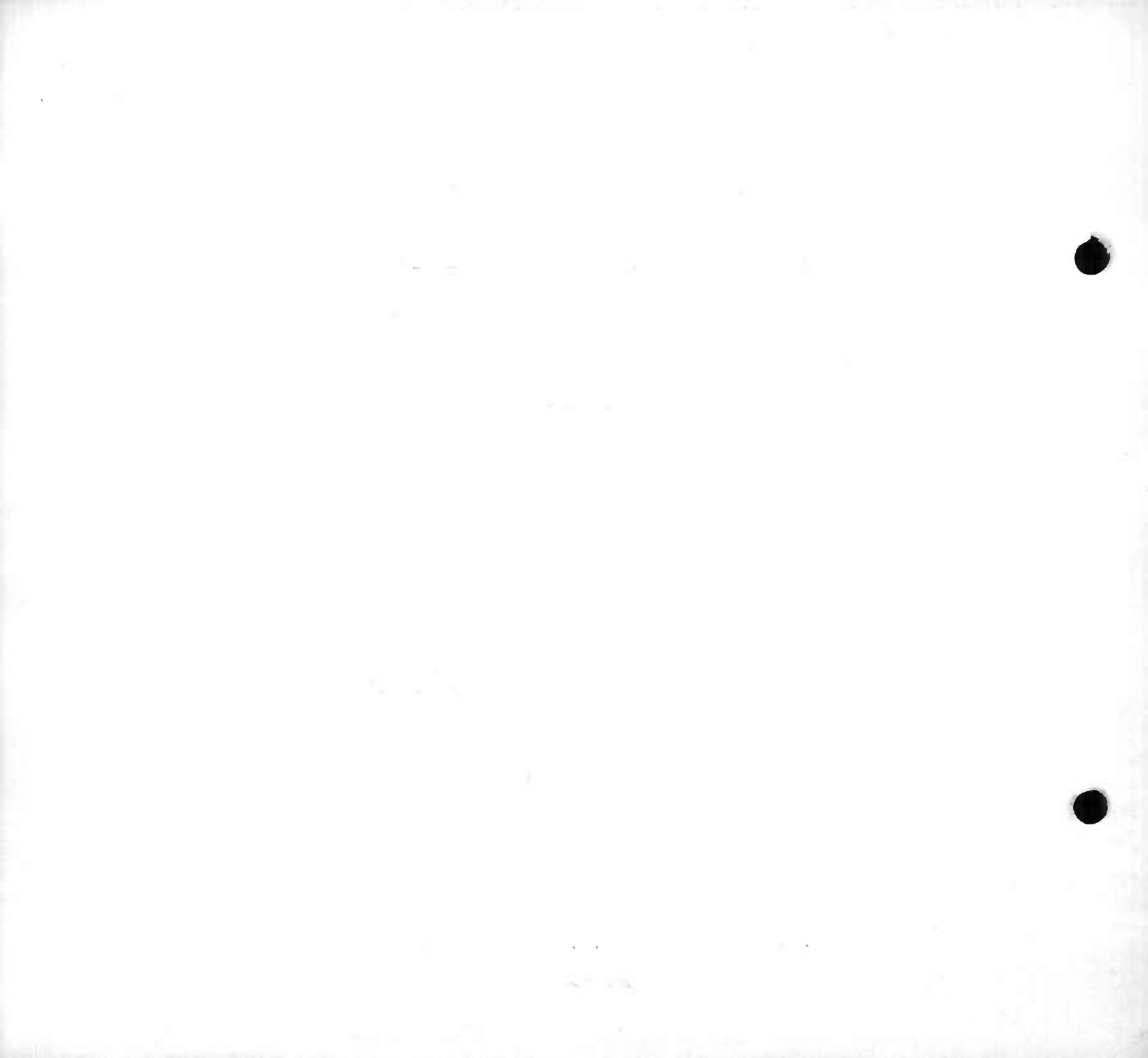
1000 Broadway



# FUNERAL DIRECTOR: IMPORTANT

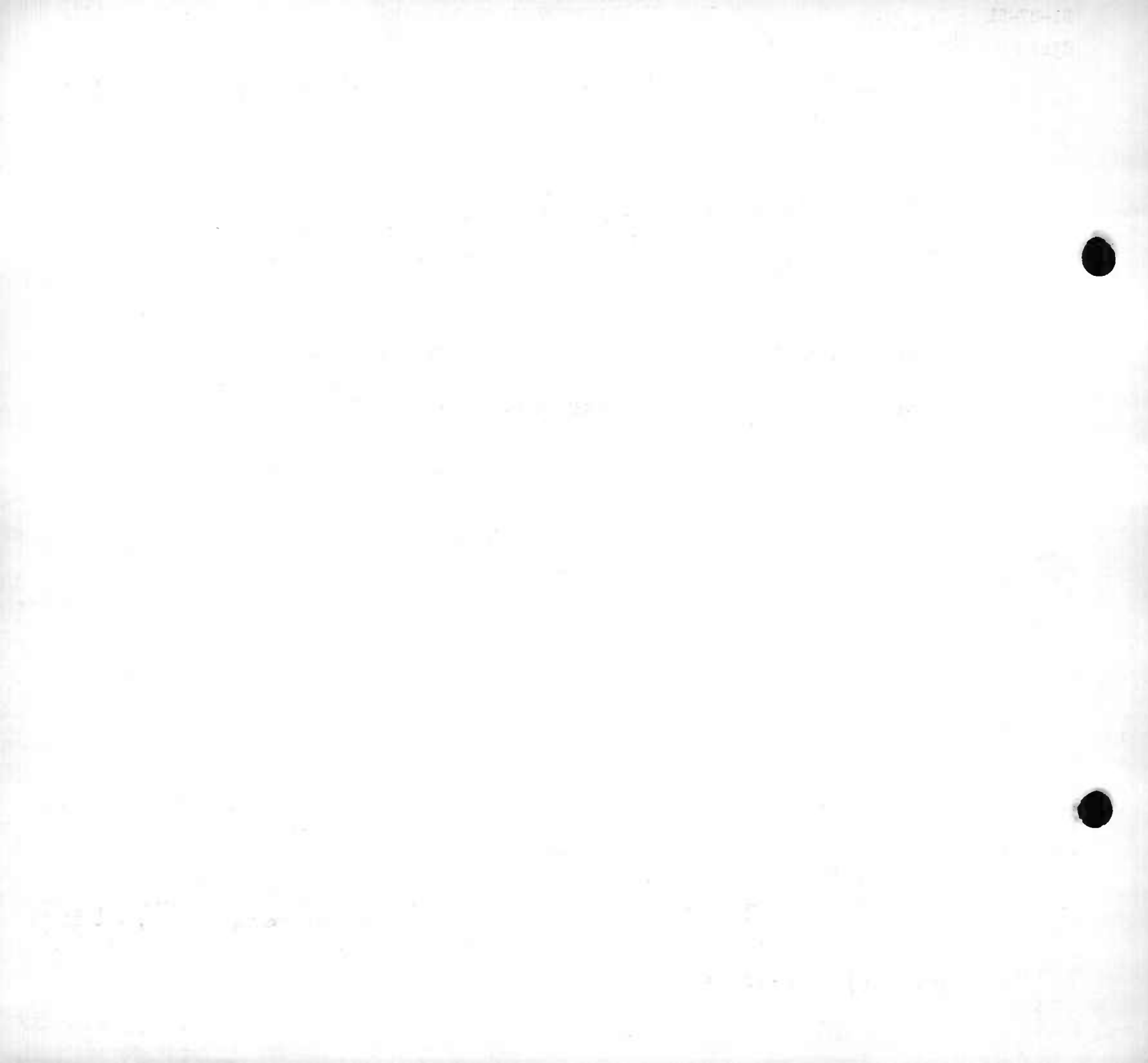
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <u>A-400</u>                                                                                                                                                                                                                                                                                                                                               |  |                         |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |  |                                                           |  | 70 7957                                                                                                                                             |  |                                                                             |  | CERTIFICATE OF DEATH                                                                                                                            |  |                                   |  | X REG. NO. <u>70 7957</u> |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------|--|---------------------------|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>CAMSIE HALL</u>                                                                                                                                                                                                                                                                                                            |  |                         |  |                                                                                                                                                             |  |                                                           |  | 2. DATE AND HOUR OF DEATH<br><u>08-08-70</u> <u>10:50 A. M.</u>                                                                                     |  |                                                                             |  |                                                                                                                                                 |  |                                   |  |                           |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                               |  |                         |  |                                                                                                                                                             |  |                                                           |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>MARYLAND</u> B. COUNTY <u>ANNE ARUNDEL</u>     |  |                                                                             |  |                                                                                                                                                 |  |                                   |  |                           |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>THE JOHNS HOPKINS HOSPITAL</u><br><u>BALTIMORE, MD 21205</u>                                                                                                                                                                                         |  |                         |  |                                                                                                                                                             |  |                                                           |  | C. CITY OR TOWN<br><u>GLEN BURNIE</u>                                                                                                               |  |                                                                             |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                              |  |                                   |  |                           |  |  |  |
| E. STREET AND NUMBER<br><u>BOX 96 #5 HOWARD ROAD</u>                                                                                                                                                                                                                                                                                                                 |  |                         |  |                                                                                                                                                             |  |                                                           |  | 5200                                                                                                                                                |  |                                                                             |  |                                                                                                                                                 |  |                                   |  |                           |  |  |  |
| 5. SEX<br><u>FEMALE</u>                                                                                                                                                                                                                                                                                                                                              |  | 6. RACE<br><u>NEGRO</u> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>02-25-93</u>                       |  | 9. AGE (In years last birthday)<br><u>77</u>                                                                                                        |  | If Under 1 Yr. Months Days                                                  |  | If Under 24 Hrs. Hours Min.                                                                                                                     |  |                                   |  |                           |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                                                                                                                                                                                                                      |  |                         |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |  |                                                           |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                                                                        |  |                                                                             |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                                      |  |                                   |  |                           |  |  |  |
| 13. FATHER'S NAME<br><u>JOSEPH BURLEY</u>                                                                                                                                                                                                                                                                                                                            |  |                         |  |                                                                                                                                                             |  |                                                           |  | 14. MOTHER'S MAIDEN NAME<br><u>RACHEL HENSON</u>                                                                                                    |  |                                                                             |  |                                                                                                                                                 |  |                                   |  |                           |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                                |  |                         |  |                                                                                                                                                             |  |                                                           |  | 16. SOCIAL SECURITY NO.<br><u>212-44-9680</u>                                                                                                       |  | 17. INFORMANT<br><u>Rachel Brown</u> ADDRESS <u>Annapolis Md</u>            |  |                                                                                                                                                 |  |                                   |  |                           |  |  |  |
| 18. <u>412.41</u> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |                         |  |                                                                                                                                                             |  |                                                           |  | (A) IMMEDIATE CAUSE <u>Uremia, ASCUD, pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |  |                                                                             |  |                                                                                                                                                 |  |                                   |  |                           |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                               |  |                         |  |                                                                                                                                                             |  |                                                           |  |                                                                                                                                                     |  |                                                                             |  |                                                                                                                                                 |  |                                   |  |                           |  |  |  |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                                   |  |                         |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                           |  | 20A. AUTOPSY? (Yes or No)<br><u>Per 450 pending</u>                                                                                                 |  |                                                                             |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                            |  |                                   |  |                           |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                       |  |                         |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  |                                                           |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                         |  |                                                                             |  |                                                                                                                                                 |  |                                   |  |                           |  |  |  |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                            |  |                         |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  |                                                           |  | 21F. HOW DID INJURY OCCUR?                                                                                                                          |  |                                                                             |  |                                                                                                                                                 |  |                                   |  |                           |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/1/70</u> 19 <u>70</u> to <u>8/8</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>8/8/70 10:50 AM</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.    |  |                         |  |                                                                                                                                                             |  |                                                           |  |                                                                                                                                                     |  |                                                                             |  |                                                                                                                                                 |  |                                   |  |                           |  |  |  |
| 23A. SIGNATURE<br><u>Knute S. Alfredson</u>                                                                                                                                                                                                                                                                                                                          |  |                         |  |                                                                                                                                                             |  |                                                           |  |                                                                                                                                                     |  |                                                                             |  | A. D. OEGREE<br>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  | 23B. DATE SIGNED<br><u>8/8/70</u> |  |                           |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>KNUTE S. ALFREDSON</u>                                                                                                                                                                                                                                                                                                            |  |                         |  |                                                                                                                                                             |  |                                                           |  |                                                                                                                                                     |  |                                                                             |  | 23D. ADDRESS<br><u>M. D. THE JOHNS HOPKINS HOSPITAL</u>                                                                                         |  |                                   |  |                           |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                            |  |                         |  | 24B. DATE<br><u>8-12-70</u>                                                                                                                                 |  | 24C. NAME of CEMETERY or CREMATORY<br><u>Int. Calvary</u> |  |                                                                                                                                                     |  | 24D. LOCATION (City, town, or county) (State)<br><u>Annapolis County Md</u> |  |                                                                                                                                                 |  |                                   |  |                           |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>AUG 11 1970</u>                                                                                                                                                                                                                                                                                                                |  |                         |  | 25B. NAME OF REGISTRAR<br><u>Robert E. Farley, M.D.</u>                                                                                                     |  |                                                           |  | 25C. FUNERAL DIRECTOR<br><u>Edwin W. Brantley, Jr.</u>                                                                                              |  |                                                                             |  | ADDRESS                                                                                                                                         |  |                                   |  |                           |  |  |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                      |  |                                                                                                                   |  |                                                                                                                                                             |  |                                                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|
| 51-27-51                                                                                                                                                                                                                                                                                                                                               |  | C-4/6                                                                                                                                                                                |  | 70 7958                                                                                                           |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |  | 70 7958                                                                        |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                              |  | 70 7958                                                                                                                                                                              |  |                                                                                                                   |  | CERTIFICATE OF DEATH                                                                                                                                        |  |                                                                                |  |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                 |  | Colbert, George                                                                                                                                                                      |  |                                                                                                                   |  | 2. DATE AND HOUR OF DEATH<br>8/6/70 8:20 AM                                                                                                                 |  |                                                                                |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                 |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE<br>Maryland                                                                        |  |                                                                                                                   |  | B. COUNTY<br>2102                                                                                                                                           |  |                                                                                |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>Baltimore City Hospitals<br>4940 Eastern Avenue Baltimore, Maryland                                                                                                                                                                                                                                            |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                 |  | C. CITY OR TOWN<br>Baltimore                                                                                      |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                               |  |                                                                                |  |
| E. STREET AND NUMBER<br>613 Archer Street 21230                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br>Male                                                                                                                                                                       |  | 6. RACE<br>Negro                                                                                                  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>5-7-10                                                     |  |
| 9. AGE (In years last birthday)<br>60                                                                                                                                                                                                                                                                                                                  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                           |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                 |  | 11. BIRTHPLACE (State or foreign country)<br>Virginia                                                                                                       |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                         |  |
| 13. FATHER'S NAME<br>James Colbert                                                                                                                                                                                                                                                                                                                     |  | 14. MOTHER'S MAIDEN NAME<br>Sarah Frances                                                                                                                                            |  | 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br>No |  | 16. SOCIAL SECURITY NO.<br>215-05-7787                                                                                                                      |  | 17. INFORMANT<br>BCH: Records 4940 Eastern Avenue<br>Baltimore, Maryland 21224 |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | (A) IMMEDIATE CAUSE<br>Uncol. herniation<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) Prob. Cerebello-pontic angle mass<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) Prob. Vascular lesion |  |                                                                                                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |  |                                                                                |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                 |  | 19A. DATE OF OPERATION                                                                                                                                                               |  |                                                                                                                   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)<br>No                                                |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                                                  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                             |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                       |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                        |  |                                                                                |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                              |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                            |  | 21F. HOW DID INJURY OCCUR?                                                                                        |  |                                                                                                                                                             |  |                                                                                |  |
| 22. I certify that (this hospital) attended the deceased from 8/3/70 to 8/6/70 that (we) last saw the deceased alive on 8/6/70 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (didn't) view the body after death.                                                                      |  | 23A. SIGNATURE<br>EDUARDO MAZZI                                                                                                                                                      |  | 23B. DATE SIGNED<br>August 6, 1970                                                                                |  | 23C. PHYSICIAN'S NAME (Type)<br>EDUARDO MAZZI                                                                                                               |  | 23D. ADDRESS<br>Baltimore City Hospitals                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                               |  | 24B. DATE<br>8-10-70                                                                                                                                                                 |  | 24C. NAME OF CEMETERY or CREMATORY<br>Mt. CALVERY                                                                 |  | 24D. LOCATION (City, town, or county) (State)<br>Brooklyn, MARYLAND                                                                                         |  |                                                                                |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>AUG 11 1970                                                                                                                                                                                                                                                                                                         |  | 25B. NAME OF REGISTRAR<br>Robert E. Faby...                                                                                                                                          |  | 25C. FUNERAL DIRECTOR<br>CHARLES A. Rice                                                                          |  | 25D. ADDRESS<br>661 W. BARRE ST.                                                                                                                            |  |                                                                                |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                        |                                           |                                                                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------|--|
| D-250                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     | 70 7959                                                                                                                                                     |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                       |                                           | 70 7959                                                                                       |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                     |                                                                                                                                                             |  | CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                   |                                           |                                                                                               |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>WALKER DAWSON</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br><b>8/4/70</b> <b>4:15 P.M.</b>                                                                                                                                                                                                                                                                                            |                                           |                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO.</b>                                                                                                                                                                                                              |                                           |                                                                                               |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>44 UNION MEMORIAL HOSPITAL</b>                                                                                                                                                                                                                                                                                                               |                     |                                                                                                                                                             |  | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                    |                                           | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                             |  | E. STREET AND NUMBER<br><b>8034 NORRIS LANE</b>                                                                                                                                                                                                                                                                                                        |                                           |                                                                                               |  |
| 5. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           | 6. RACE<br><b>N</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>2/5/193</b>                                                                                                                                                                                                                                                                                                                     | 9. AGE (In years last birthday) <b>70</b> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                                        |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                      |                                           | 11. BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>                                  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             |  | 13. FATHER'S NAME<br><b>Bronson Dawson</b>                                                                                                                                                                                                                                                                                                             |                                           |                                                                                               |  |
| 14. MOTHER'S MAIDEN NAME<br><b>unk.</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                             |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                  |                                           |                                                                                               |  |
| 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                             |  | 17. INFORMANT<br><b>MRS. BESSIE DAWSON</b>                                                                                                                                                                                                                                                                                                             |                                           |                                                                                               |  |
| 18. <b>44101</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CARDIAC ARREST</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Dissecting Aortic Aneurysm</b><br><b>Hypertension</b><br><b>Stenosis</b> |                     |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                                           |                                           |                                                                                               |  |
| 19A. DATE OF OPERATION<br><b>8/4/70</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                             |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                       |                                           | 20A. AUTOPSY? (Yes or No)                                                                     |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                      |                                           |                                                                                               |  |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                                             |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                               |                                           |                                                                                               |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                                                                                                                                                             |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                              |                                           |                                                                                               |  |
| 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     |                                                                                                                                                             |  | 22. I certify that (I) (this hospital) attended the deceased from <b>7/29</b> 19 <b>70</b> to <b>8/4</b> 19 <b>70</b><br>that (I) (we) last saw the deceased alive on <b>8/4</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                           |                                                                                               |  |
| 23A. SIGNATURE<br><b>H.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             |  | 23B. DATE SIGNED<br><b>8/4/70</b>                                                                                                                                                                                                                                                                                                                      |                                           | 23C. PHYSICIAN'S NAME (Type)<br><b>Carlos E. Fossi</b>                                        |  |
| 23D. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                               |                     |                                                                                                                                                             |  | 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                             |                                           |                                                                                               |  |
| 24B. DATE<br><b>8-8-70</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     |                                                                                                                                                             |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>mt Calvary</b>                                                                                                                                                                                                                                                                                                |                                           | 24D. LOCATION (City, town, or county) (State)<br><b>Brooklyn, Maryland</b>                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>AUG 11 1970</b>                                                                                                                                                                                                                                                                                                                                                                                                        |                     |                                                                                                                                                             |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fossi</b>                                                                                                                                                                                                                                                                                                       |                                           | 25C. FUNERAL DIRECTOR<br><b>Charles G. Lee</b>                                                |  |
| 25D. ADDRESS<br><b>661 W. Baltimore St.</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                        |                                           |                                                                                               |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                          | REG. NO. <u>70 7960</u>                                                            |                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. <u>M-400 70 7960</u>                                                                                                                                                                                                                                                                                                             |                         | CERTIFICATE OF DEATH                                                                                                                                        |                                          |                                                                                    |                                                           |
| 1. NAME OF DECEASED<br>(Type or Print) <u>John Meli</u>                                                                                                                                                                                                                                                                                    |                         | 2. DATE AND HOUR OF DEATH<br><u>August 8, 1970</u> <u>12:15 A.M.</u> M.                                                                                     |                                          |                                                                                    |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br><u>90 Mount Sinai Nursing Home</u>                                                                                                                                                                                                                                           |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>2716</u>                     |                                          |                                                                                    |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>90 Mount Sinai Nursing Home</u>                                                                                                                                                                                            |                         | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                         |                                          | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                           |
|                                                                                                                                                                                                                                                                                                                                            |                         | E. STREET AND NUMBER<br><u>4613 Park Heights Ave.</u>                                                                                                       |                                          |                                                                                    |                                                           |
| 5. SEX<br><u>Male</u>                                                                                                                                                                                                                                                                                                                      | 6. RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><u>Feb. 25, 1900</u> | 9. AGE (In years last birthday)<br><u>70</u>                                       | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Cab driver</u>                                                                                                                                                                                                                           |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                          | 11. BIRTHPLACE (State or foreign country)<br><u>Sicily</u>                         |                                                           |
| 13. FATHER'S NAME<br><u>Ignatius Meli</u>                                                                                                                                                                                                                                                                                                  |                         | 14. MOTHER'S MAIDEN NAME<br><u>Josephine Giordino</u>                                                                                                       |                                          | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                      |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                      |                         | 16. SOCIAL SECURITY NO.<br><u>217-01-6670</u>                                                                                                               |                                          | 17. INFORMANT<br><u>Robert W. Gaver, 4304 Greenhill Ave.</u>                       |                                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>Intestinal Carcinoma with Metastases to Liver</u>                                                                                 |                         | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>Metastases to Liver</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____  |                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2</u>                           |                                                           |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>II</u>                                                                                                                                                                                            |                         |                                                                                                                                                             |                                          |                                                                                    |                                                           |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                          |                                                                                    |                                                           |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                         |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                          | 20A. AUTOPSY? (Yes or No)<br><u>No</u>                                             |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                                      |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)           |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                          | 21F. HOW DID INJURY OCCUR?                                                         |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July 14 1970</u> to <u>August 8 1970</u> that (I) (we) last saw the deceased alive on <u>Aug 7 1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did</u> (did not) view the body after death. |                         |                                                                                                                                                             |                                          |                                                                                    |                                                           |
| 23A. SIGNATURE<br><u>Louis T. Lavy, M.D.</u>                                                                                                                                                                                                                                                                                               |                         | 23B. PHYSICIAN'S NAME (Type)<br><u>Louis T. Lavy, M.D.</u>                                                                                                  |                                          | 23C. DATE SIGNED<br><u>Aug 8 - 1970</u>                                            |                                                           |
| 23D. ADDRESS<br><u>3502 W. Rogers Ave. Baltimore Md 15</u>                                                                                                                                                                                                                                                                                 |                         | 23E. ADDRESS<br><u>3502 W. Rogers Ave. Baltimore Md 15</u>                                                                                                  |                                          |                                                                                    |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                  |                         | 24B. DATE<br><u>8/30/70</u>                                                                                                                                 |                                          | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Woodlawn Cemetery</u>                     |                                                           |
| 24D. LOCATION (City, town, or county) (State)<br><u>Woodlawn, Md.</u>                                                                                                                                                                                                                                                                      |                         | 24E. LOCATION (City, town, or county) (State)<br><u>Woodlawn, Md.</u>                                                                                       |                                          |                                                                                    |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>AUG 11 1970</u>                                                                                                                                                                                                                                                                                      |                         | 25B. NAME OF REGISTRAR<br><u>Robert E. Tabor, M.D.</u>                                                                                                      |                                          | 25C. FUNERAL DIRECTOR<br><u>Ullrich Funeral Home 4210 Belair Road.</u>             |                                                           |



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S-330 70 7961 BALTIMORE CITY HEALTH DEPARTMENT X

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7961

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br>William F. Stott Sr.                                                                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> 8 3 70 8:29 p.m.                                             |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>38 University Hospital                                                                                                                                                                                                                                                                                      |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>8 3 70 8:29 p.m.                                                                                            |  |
| 6. SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                |  | 7. RACE<br>Negro                                                                                                                                              |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                   |  | C. CITY OR TOWN<br>Baltimore, Riverdale                                                                                                                       |  |
| 9. DATE OF BIRTH<br>12-7-46                                                                                                                                                                                                                                                                                                                                                                                   |  | 10. AGE (in years last birthday)<br>23                                                                                                                        |  |
| 11. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                         |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                        |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer                                                                                                                                                                                                                                                                                                        |  | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                             |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                       |  | 17. SOCIAL SECURITY NO.                                                                                                                                       |  |
| 13. FATHER'S NAME<br>Leon Stott                                                                                                                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>Charlotte Herbert                                                                                                                 |  |
| 18. INFORMANT<br>Havana E. Scott                                                                                                                                                                                                                                                                                                                                                                              |  | ADDRESS                                                                                                                                                       |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>E812.1<br>Craniocerebral injury                                                                                                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                        |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                              |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                           |  |
| 20A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                        |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                              |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                               |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Street                                                            |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>N.B.I 70 1/2 mile N. Md. Rt 80, Urbana, Frederick Co.                                                                                                                                                                                                                                                                             |  | 22E. HOW DID INJURY OCCUR?<br>Subject was passenger in car which was struck in rear by tractor & trailer.                                                     |  |
| 22D. TIME OF INJURY (APPROX.)<br>8 1 70 2:50 p.m.                                                                                                                                                                                                                                                                                                                                                             |  | 22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                        |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 21. AUTOPSY? (Yes or No)                                                                                                                                      |  |
| ACTUAL SIGNATURE<br>Werner U. Spatz, M.D.<br>Deputy Chief Medical Examiner                                                                                                                                                                                                                                                                                                                                    |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |
| DATE SIGNED<br>8/4/70                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                               |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                            |  | 24B. DATE<br>8-8-70                                                                                                                                           |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>Harmony Memorial Park                                                                                                                                                                                                                                                                                                                                                   |  | 24D. LOCATION (City, town, or county) (State)<br>Landover, Md.                                                                                                |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>AUG 11 1970 Robert E. Farber, M.D.                                                                                                                                                                                                                                                                                                                                         |  | 25B. NAME OF REGISTRAR                                                                                                                                        |  |
| 25C. FUNERAL DIRECTOR<br>John T. Rhines & Co., 3030-12th-St., N.E.                                                                                                                                                                                                                                                                                                                                            |  | ADDRESS                                                                                                                                                       |  |

VS 151-REV. 1/1/68

Order of the Board of Directors  
andover

W. J. Wilson  
President

W. J. Wilson

W. J. Wilson

W. J. Wilson

W. J. Wilson

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <u>D-136</u> <u>70</u> <u>7962</u>                                                                                                                                                                                                                                                                                                                                                                                      |                      | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                            |                                                                                                                                                                                                                                                                                                                                | REG. NO. <u>70</u> <u>7962</u>                                           |                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <u>DI PIETRO, Ralph Harry</u><br><u>Di Pietro, Ralph</u>                                                                                                                                                                                                                                                                                                                                   |                      |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><u>8-5-70</u> <u>17:56</u> <u>P</u> M.                                                                                                                                                                                                                                                            |                                                                          |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>42 Sinai Hospital Inc.</u>                                                                                                                                                                                                                          |                      |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <u>md.</u> B. COUNTY <u>Baltimore City</u><br>C. CITY OR TOWN <u>city</u> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>E. STREET AND NUMBER <u>Belvedere at Greenspring</u> |                                                                          |                                                           |
| 5. SEX <u>male</u>                                                                                                                                                                                                                                                                                                                                                                                                                | 6. RACE <u>Cauc.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-5-06</u>                                                                                                                                                                                                                                                                                                 | 9. AGE (in years last birthday) <u>63 1/2</u>                            | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Bricklayer</u>                                                                                                                                                                                                                                                                                                                  |                      | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Building</u>                                                                                                        | 11. BIRTHPLACE (State or foreign country)<br><u>Boswell, Pennsylvania</u>                                                                                                                                                                                                                                                      |                                                                          | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>             |
| 13. FATHER'S NAME<br><u>Joseph DiPietro</u>                                                                                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><u>Clorinda Varrato</u>                                                                                                                                                                                                                                                                            |                                                                          |                                                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>Yes</u> <u>WW II</u>                                                                                                                                                                                                                                                                                               |                      | 16. SOCIAL SECURITY NO.<br><u>212 16 8138</u>                                                                                                               | 17. INFORMANT <u>Balto. Md. 21215</u><br><u>Mrs. Mary E. DiPietro 3208 Ingleside Ave.</u>                                                                                                                                                                                                                                      |                                                                          |                                                           |
| 18. <u>412.41</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><u>cardiac arrest</u><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>probably ASCVD &amp; mitral regurgitation</u> |                      |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                                                                                   |                                                                          |                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                            |                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                |                                                                          |                                                           |
| 19A. DATE OF OPERATION <u>0</u>                                                                                                                                                                                                                                                                                                                                                                                                   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                                                | 20A. AUTOPSY? (Yes or No)                                                |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)                                                                                                                                                                                                                                                                                                                                             |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                                                | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                           |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                         |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                                                                                                                                                                | 21F. HOW DID INJURY OCCUR?                                               |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8-5-70</u> 19 <u>70</u> to <u>8-5</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>7-7</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                             |                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                |                                                                          |                                                           |
| 23A. SIGNATURE<br><u>Harumi Sadamoto M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                | 23B. DATE SIGNED<br><u>8-8-70</u>                                        |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Harumi Sadamoto M.D.</u>                                                                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                | 23D. ADDRESS<br><u>Sinai Hospital, Baltimore</u>                         |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                         |                      | 24B. DATE<br><u>10 AUG 70</u>                                                                                                                               |                                                                                                                                                                                                                                                                                                                                | 24C. NAME OF CEMETERY or CREMATORY<br><u>Loudon National Cemetery</u>    |                                                           |
| 24D. LOCATION<br><u>Baltimore, Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                       |                      | 25A. DATE REC'D BY HEALTH DEPT.<br><u>AUG 11 1970</u>                                                                                                       |                                                                                                                                                                                                                                                                                                                                |                                                                          |                                                           |
| 25B. NAME OF REGISTRAR<br><u>Robert E. Farber, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                           |                      | 25C. FUNERAL DIRECTOR<br><u>J. E. Lowell Hemmon</u>                                                                                                         |                                                                                                                                                                                                                                                                                                                                |                                                                          |                                                           |
| 25D. ADDRESS<br><u>6500 York Road</u>                                                                                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                |                                                                          |                                                           |

3208 Ingle-side Ave

Sinai stated Patient was a

DOA in the Emergency Ward.

CT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7963

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CLYDE E. MILLER, SR.

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

301 Birkwood Avenue

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

August 7, 1970

7:30 P

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

1202

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

10-15-1900

10. AGE (in years  
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

301 Birkwood Avenue

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

HARRY MILLER

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

CITECKER

14B. KIND OF BUSINESS OR INDUSTRY

WATER FRONT

15. MOTHER'S MAIDEN NAME

ANNIE MORROW

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL  
SECURITY NO.

218-05-2923

18. INFORMANT

721850LLERS RD. ADDRESS  
HAROLD C. MILLER (BROTHER) 21222

19.

412.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 8, 1970

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

8-10-1970

24C. NAME OF CEMETERY or CREMATORY

BALTIMORE

24D. LOCATION (City, town, or county)

BALTIMORE, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 11 1970

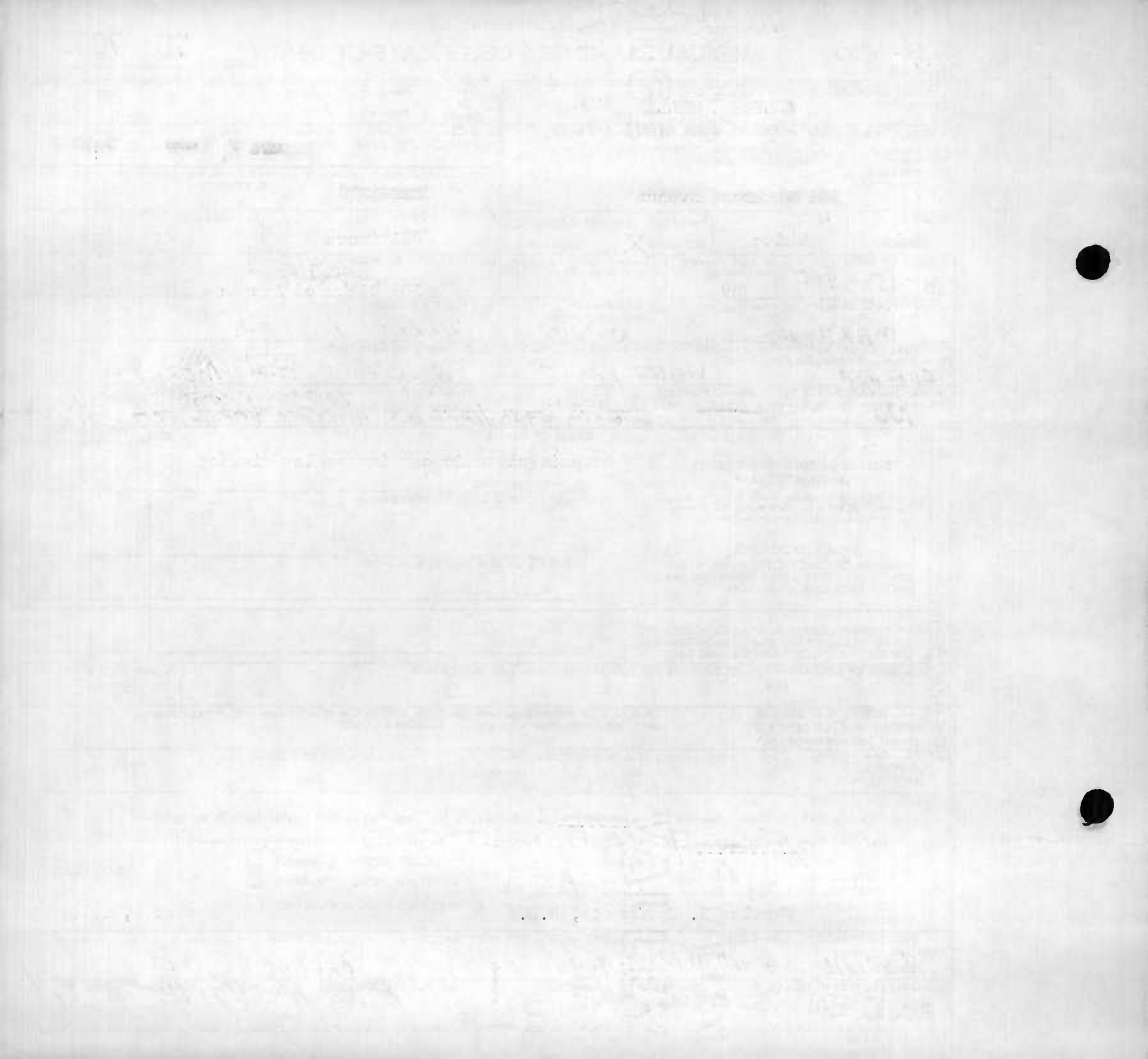
25B. NAME OF REGISTRAR

Robert E. Gable

25C. FUNERAL DIRECTOR

W. Frank Dooly, Baltimore, Md.

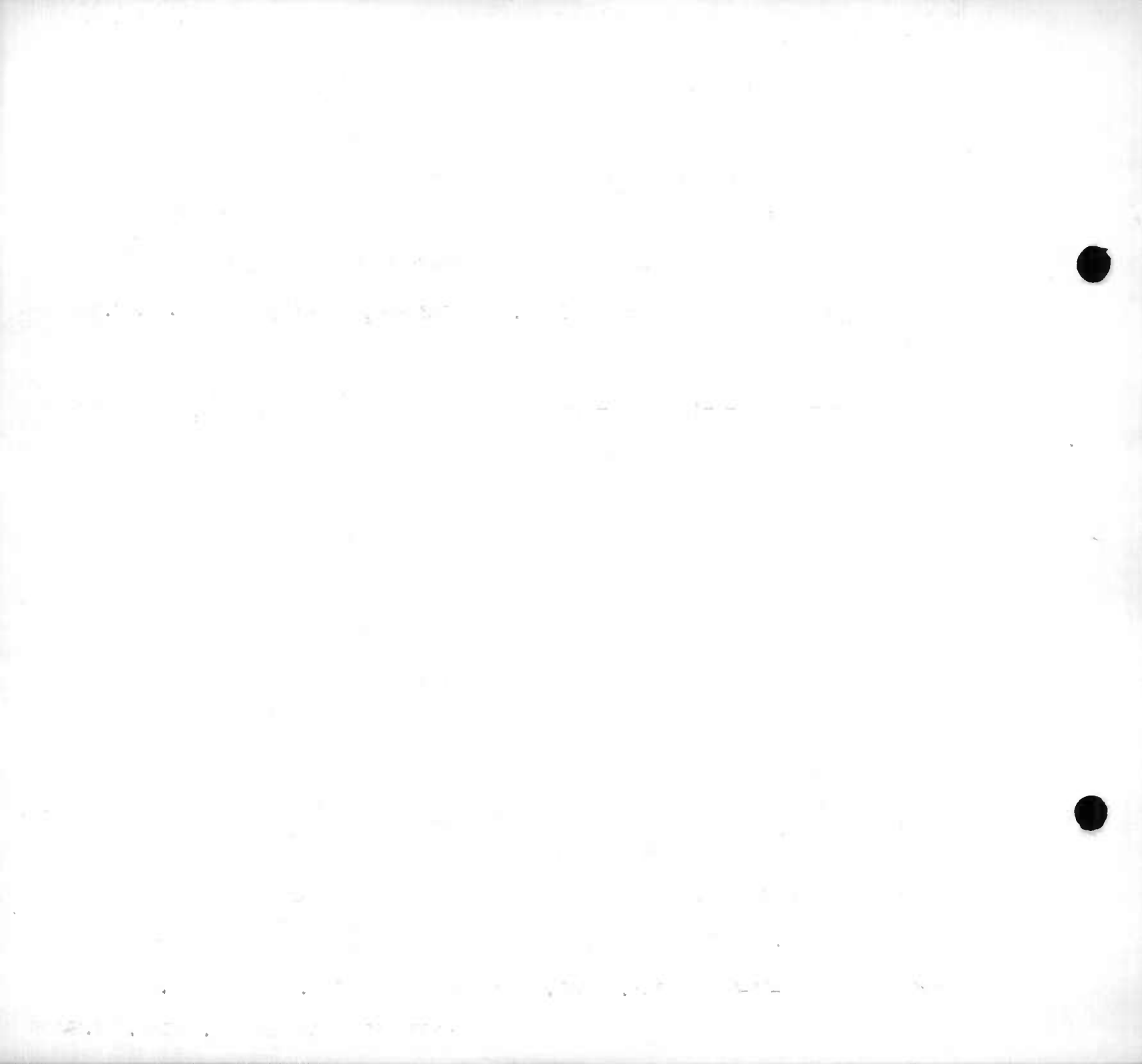
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

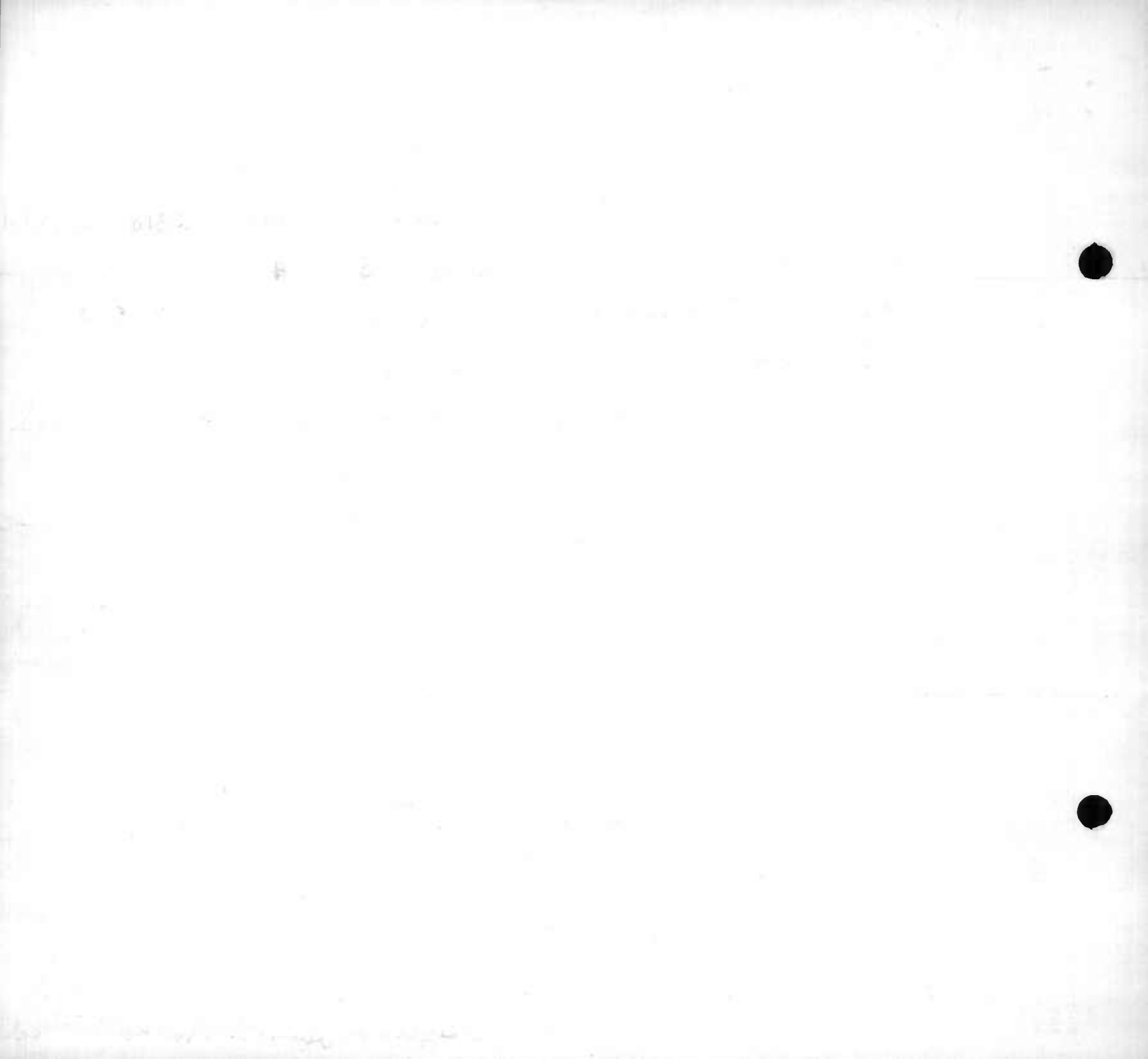
| M-600 70 7964                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             |                                                                                                                                                             |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                |                                                | 70 7964                                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                             |                                                                                                                                                             |  | CERTIFICATE OF DEATH                                                                                                            |                                                | REG. NO.                                                                                   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MURRAY, William P</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                             |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br><b>8 AUGUST 1970</b>                                                                               |                                                | <b>6:15 A</b> M.                                                                           |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                             |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                           |                                                |                                                                                            |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>23 VETERANS ADMINISTRATION HOSPITAL</b><br><b>3900 LOCH RAVEN BOULEVARD</b><br><b>BALTIMORE, MARYLAND 21218</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |                             |                                                                                                                                                             |  | A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b>                                                                        |                                                |                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                             |                                                                                                                                                             |  | C. CITY OR TOWN <b>BALTIMORE</b>                                                                                                |                                                | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                             |                                                                                                                                                             |  | E. STREET AND NUMBER<br><b>906 N CALVERT STREET 21202</b>                                                                       |                                                |                                                                                            |  |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 6. RACE<br><b>CAUCASION</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>4-1-96 1897</b>                                                                                          | 9. AGE (In years last birthday)<br><b>74 3</b> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>IRON WORKER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>McNamara Steel Co.</b>                                                                                              |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>                                                         |                                                | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                            |  |
| 13. FATHER'S NAME<br><b>JOHN MURRAY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br><b>MARY</b>                                                                                         |                                                |                                                                                            |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES 6-8-17 TO 6-2-19</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             | 16. SOCIAL SECURITY NO.<br><b>218-07-8417</b>                                                                                                               |  | 17. INFORMANT <b>VA HOSPITAL RECORDS</b> ADDRESS<br><b>3900 LOCH RAVEN BLVD, BALTO, MD 21218</b>                                |                                                |                                                                                            |  |
| 18. <b>I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Post-surgical (R) pneumonia</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>(A) IMMEDIATE CAUSE I poorly diff squamous cell carcin 2+</b><br><b>Gastroesophageal malacia</b><br><b>(B) Rupture of esophagus, acute</b><br><b>(C) mediastinitis, acute</b> |                             |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b><br><b>1 hour</b><br><b>1 hour</b>                                 |                                                |                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                             |                                                                                                                                                             |  |                                                                                                                                 |                                                |                                                                                            |  |
| 19A. DATE OF OPERATION<br><b>38-3-70</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma of lung</b>                                                                                |  | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>                                                                                         |                                                | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b>         |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><input type="checkbox"/>                                        |  | 21C. WHERE DID INJURY OCCUR?<br><input type="checkbox"/>                                                                        |                                                | (If in Baltimore City, give exact location)                                                |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)<br><b>---</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?<br><b>---</b>                                                                                        |                                                |                                                                                            |  |
| 22. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>22 JULY</b> 19 <b>70</b> to <b>8 AUGUST</b> 19 <b>70</b> that <b>(X)</b> (we) last saw the deceased alive on <b>8 AUGUST</b> 19 <b>70</b> and that <b>(in my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (We) (did) <b>(not see)</b> view the body after death.                                                                                                                                                                        |                             |                                                                                                                                                             |  |                                                                                                                                 |                                                |                                                                                            |  |
| 23A. SIGNATURE<br><b>Don W Bryan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                             |                                                                                                                                                             |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                                                | 23B. DATE SIGNED                                                                           |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>DON W. BRYAN MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                             |                                                                                                                                                             |  | 23D. ADDRESS<br><b>3900 LOCH RAVEN BLVD</b><br><b>BALTIMORE, MARYLAND 21218</b>                                                 |                                                |                                                                                            |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                             | 24B. DATE<br><b>8-12-70</b>                                                                                                                                 |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Nat'l. Cemetery</b>                                                             |                                                | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>                         |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>AUG 11 1970</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                             | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, MD</b>                                                                                                       |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>McCully 237 Patapsco Ave. Balto. Md. 21225</b>                                              |                                                |                                                                                            |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

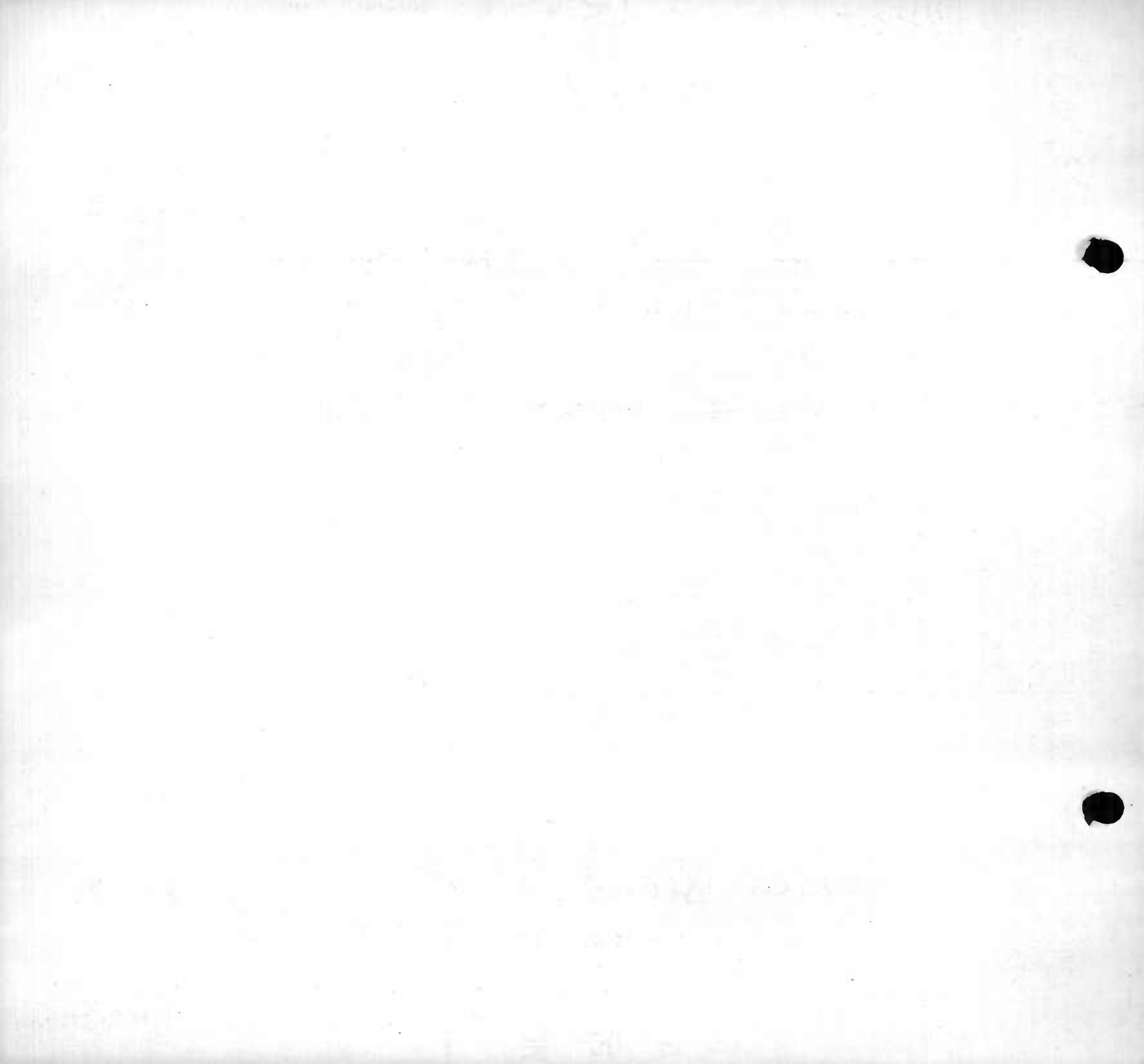
| Baltimore City Health Department                                                                                                                                                                                                                                                                                                    |           |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                 | REG. NO. 70 7965                                                         |                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------|
| K-145 70 7965                                                                                                                                                                                                                                                                                                                       |           | BIRTH NO.                                                                                                                                                   |                                                                                                                                                                                                                                                                                                 | 70 7965                                                                  |                                  |
| 1. NAME OF DECEASED<br>(Type or Print) KOPPELMAN SAMUEL                                                                                                                                                                                                                                                                             |           |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br>8/7/1970 12:35 A.M.                                                                                                                                                                                                                                                |                                                                          |                                  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>42 SINAI HOSPITAL OF BALTIMORE                                                                                                                               |           |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE Md B. COUNTY 2755<br>C. CITY OR TOWN Balto D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER 4601 Pull Mall Rd. 2310 South Rd |                                                                          |                                  |
| 5. SEX M                                                                                                                                                                                                                                                                                                                            | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH OCT 12/1885                                                                                                                                                                                                                                                                    | 9. AGE (In years last birthday) 84                                       | 10. CITIZEN OF WHAT COUNTRY? USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret                                                                                                                                                                                                                                     |           |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY Tailor                                                                                                                                                                                                                                                        |                                                                          |                                  |
| 13. FATHER'S NAME Zelman                                                                                                                                                                                                                                                                                                            |           |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME Sarah                                                                                                                                                                                                                                                                  |                                                                          |                                  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO                                                                                                                                                                                                                         |           |                                                                                                                                                             | 16. SOCIAL SECURITY NO. 063-09-1142                                                                                                                                                                                                                                                             |                                                                          |                                  |
| 17. INFORMANT Mrs. Tess Zelman                                                                                                                                                                                                                                                                                                      |           |                                                                                                                                                             | ADDRESS 2310 South Rd                                                                                                                                                                                                                                                                           |                                                                          |                                  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |           |                                                                                                                                                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) ATHEROSCLEROTIC CARDIOVASC. DISEASE.<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days.                                              |                                                                          |                                  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                              |           |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                 |                                                                          |                                  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                              |           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                 | 20A. AUTOPSY? (Yes or No) NO                                             |                                  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                               |           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                           |           | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                                                                                                                                 | 21F. HOW DID INJURY OCCUR?                                               |                                  |
| 22. I certify that (A) (this hospital) attended the deceased from 8/4/70 1970 to 8/7 1970 that (B) (we) last saw the deceased alive on 8/7 1970 and that (C) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                           |           |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                 |                                                                          |                                  |
| 23A. SIGNATURE [Signature] M.D.                                                                                                                                                                                                                                                                                                     |           |                                                                                                                                                             | 23B. DATE SIGNED 8/7/70                                                                                                                                                                                                                                                                         |                                                                          |                                  |
| 23C. PHYSICIAN'S NAME (Type) ANDREAS A. PETSAS M.D.                                                                                                                                                                                                                                                                                 |           |                                                                                                                                                             | 23D. ADDRESS SINAI HOSPITAL OF BALTIMORE.                                                                                                                                                                                                                                                       |                                                                          |                                  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                     |           | 24B. DATE 8/9/70                                                                                                                                            |                                                                                                                                                                                                                                                                                                 | 24C. NAME OF CEMETERY OR CREMATORY Hebrew Young Men Balto                |                                  |
| 24D. LOCATION (City, town, or county) Md                                                                                                                                                                                                                                                                                            |           | 25A. DATE REC'D BY HEALTH DEPT. AUG 11 1970                                                                                                                 |                                                                                                                                                                                                                                                                                                 | 25B. NAME OF REGISTRAR Robert E. Fisher, RD.                             |                                  |
| 25C. FUNERAL DIRECTOR Sylvan Lewis                                                                                                                                                                                                                                                                                                  |           | 25D. ADDRESS 9610 Reisterstown Rd                                                                                                                           |                                                                                                                                                                                                                                                                                                 |                                                                          |                                  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | REG. NO. <span style="font-size: 1.5em;">70 7966</span>                                          |                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| <b>BIRTH NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print) <span style="font-size: 1.2em;">SAMUEL MORRIS BRIGGIN</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                            | <b>2. DATE AND HOUR OF DEATH</b><br><span style="font-size: 1.2em;">8/10/70</span> <span style="font-size: 1.2em;">4<sup>30</sup> a</span> M.                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                  |                                                                                  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><span style="font-size: 1.2em;">3012 FALLSTAFF MANOR CT</span><br><span style="font-size: 1.5em;">00</span>                                                                                                                                                                                                                                                                                  |                                                            | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br>A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">2730</span><br><b>5. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>6. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><b>7. STREET AND NUMBER</b> <span style="font-size: 1.2em;">3012 Fallstaff Manor Ct</span> |  |                                                                                                  |                                                                                  |
| <b>5. SEX</b><br><span style="font-size: 1.2em;">M</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>6. RACE</b><br><span style="font-size: 1.2em;">W</span> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                   |  | <b>8. DATE OF BIRTH</b><br><span style="font-size: 1.2em;">Nov 9, 1910</span>                    | <b>9. AGE</b> (In years lost birthday) <span style="font-size: 1.2em;">59</span> |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">LIBRARIAN</span>                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                            | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><span style="font-size: 1.2em;">LAW</span>                                                                                                                                                                                                                                                                                                                                                                                                    |  | <b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">New York</span> |                                                                                  |
| <b>13. FATHER'S NAME</b><br><span style="font-size: 1.2em;">MORRIS</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                            | <b>14. MOTHER'S MAIDEN NAME</b><br><span style="font-size: 1.2em;">Risa</span>                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                  |                                                                                  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">Yes</span> <span style="font-size: 1.2em;">WW II</span>                                                                                                                                                                                                                                                                                                                                                                  |                                                            | <b>16. SOCIAL SECURITY NO.</b><br><span style="font-size: 1.2em;">084-05-7500</span>                                                                                                                                                                                                                                                                                                                                                                                                      |  | <b>17. INFORMANT</b><br><span style="font-size: 1.2em;">Mildred Bruggen</span>                   |                                                                                  |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br><b>18. CAUSE OF DEATH</b><br><span style="font-size: 1.2em;">4/10/71</span> <span style="font-size: 1.2em;">Crowning Occ</span>                                                                                                                                                                                                                                   |                                                            | <b>19. ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C)                                                                                                                                                                                                                                            |  |                                                                                                  |                                                                                  |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                  |                                                                                  |
| <b>19A. DATE OF OPERATION</b><br><span style="font-size: 1.2em;">0</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                            | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | <b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">No</span>                       |                                                                                  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                            | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                           |  | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)                  |                                                                                  |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                            | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                          |  | <b>21F. HOW DID INJURY OCCUR?</b>                                                                |                                                                                  |
| <b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">10</span> <span style="font-size: 1.2em;">1967</span> <b>to</b> <span style="font-size: 1.2em;">8-10</span> <span style="font-size: 1.2em;">1970</span> , <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">8-10</span> <span style="font-size: 1.2em;">1970</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b> |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                  |                                                                                  |
| <b>23A. SIGNATURE</b><br><span style="font-size: 1.2em;">Jerome J. Coller</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | <b>23B. DATE SIGNED</b><br><span style="font-size: 1.2em;">8-10-70</span>                        |                                                                                  |
| <b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">JEROME J. COLLER M.D.</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                            | <b>23D. ADDRESS</b><br><span style="font-size: 1.2em;">2217 South Rd</span>                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                  |                                                                                  |
| <b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                            | <b>24B. DATE</b> <span style="font-size: 1.2em;">8/10/70</span>                                                                                                                                                                                                                                                                                                                                                                                                                           |  | <b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Beth David</span>      |                                                                                  |
| <b>24D. LOCATION</b> (City, town, or county) <span style="font-size: 1.2em;">Elmont</span> (State) <span style="font-size: 1.2em;">New York</span>                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                            | <b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">AUG 11 1970</span>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                  |                                                                                  |
| <b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Fisher, R.D.</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                            | <b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Sylvan Lewis</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">Son 9610 Reisterstown Rd</span>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                  |                                                                                  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                           |                     |                                                                                                                                                  |                                                                                       | REG. NO. <span style="float: right;">70 7967</span>                      |                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span>H-325-70 7967</span> <span style="font-size: 1.2em;">CERTIFICATE OF DEATH</span> </div>                                                                                                                                                                 |                     |                                                                                                                                                  |                                                                                       |                                                                          |                                                                                               |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Hudson STELLA PP.</i>                                                                                                                                                                                                                                                            |                     |                                                                                                                                                  | 2. DATE AND HOUR OF DEATH<br><i>8.8.70 6:40 A.M.</i>                                  |                                                                          |                                                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                     |                     |                                                                                                                                                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |                                                                          |                                                                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Church Home &amp; Hospital 35</i>                                                                                                                                                                                                                                               |                     |                                                                                                                                                  | A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>                                   |                                                                          |                                                                                               |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                       |                     |                                                                                                                                                  | C. CITY OR TOWN<br><i>Baltimore</i>                                                   |                                                                          | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                                  | E. STREET AND NUMBER<br><i>25 S. Decker Ave (24)</i>                                  |                                                                          |                                                                                               |
| 5. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                    | 6. RACE<br><i>w</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>10.14.1895</i>                                                 | 9. AGE (in years last birthday)<br><i>74</i>                             | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                                        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>                                                                                                                                                                                                            |                     | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                | 11. BIRTHPLACE (State or foreign country)<br><i>Del</i>                               |                                                                          | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                 |
| 13. FATHER'S NAME<br><i>Henry Johnson</i>                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                  | 14. MOTHER'S MAIDEN NAME<br><i>? Truitt</i>                                           |                                                                          |                                                                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>                                                                                                                                                                                                      |                     | 16. SOCIAL SECURITY NO.<br><i>214-50-0791</i>                                                                                                    | 17. INFORMANT<br><i>Naomi Youngblood</i> ADDRESS <i>25 S Decker Ave (24)</i>          |                                                                          |                                                                                               |
| 18. <i>03991</i> CAUSE OF DEATH                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                          |                                                                          |                                                                                               |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)                                                                                                                             |                     |                                                                                                                                                  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF: <i>Septic shock</i>            |                                                                          |                                                                                               |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                             |                     |                                                                                                                                                  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                   |                                                                          |                                                                                               |
|                                                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                                  | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                   |                                                                          |                                                                                               |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                           |                     |                                                                                                                                                  |                                                                                       |                                                                          |                                                                                               |
| 19A. DATE OF OPERATION<br><i>0</i>                                                                                                                                                                                                                                                                                         |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |                                                                                       | 20A. AUTOPSY? (Yes or No)                                                |                                                                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                      |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                         |                                                                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                                                               |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                        |                                                                                       | 21F. HOW DID INJURY OCCUR?                                               |                                                                                               |
| 22. I certify that (H) (this hospital) attended the deceased from <i>8.5.1970</i> to <i>8.8.1970</i> that (I) (we) last saw the deceased alive on <i>8.8.1970</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |                                                                                                                                                  |                                                                                       |                                                                          |                                                                                               |
| 23A. SIGNATURE<br><i>Abdur Samad MD</i>                                                                                                                                                                                                                                                                                    |                     |                                                                                                                                                  |                                                                                       | 23B. DATE SIGNED<br><i>8.8.1970</i>                                      |                                                                                               |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Abdur SAMAD MD</i>                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                  |                                                                                       | 23D. ADDRESS<br><i>Church Home &amp; Hospital Balt.</i>                  |                                                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                  |                     | 24B. DATE<br><i>8/10/70</i>                                                                                                                      |                                                                                       | 24C. NAME of CEMETERY or CREMATORY<br><i>Cedar Hill Cemetery</i>         |                                                                                               |
| 24D. LOCATION<br><i>Baltimore, Maryland</i>                                                                                                                                                                                                                                                                                |                     | 24E. NAME of REGISTRAR<br><i>John A. Moran, Inc.</i>                                                                                             |                                                                                       |                                                                          |                                                                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>AUG 11 1970</i>                                                                                                                                                                                                                                                                      |                     | 25B. NAME OF REGISTRAR<br><i>John A. Moran, Inc.</i>                                                                                             |                                                                                       | 25C. FUNERAL DIRECTOR<br><i>3000 E. Baltimore St</i>                     |                                                                                               |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

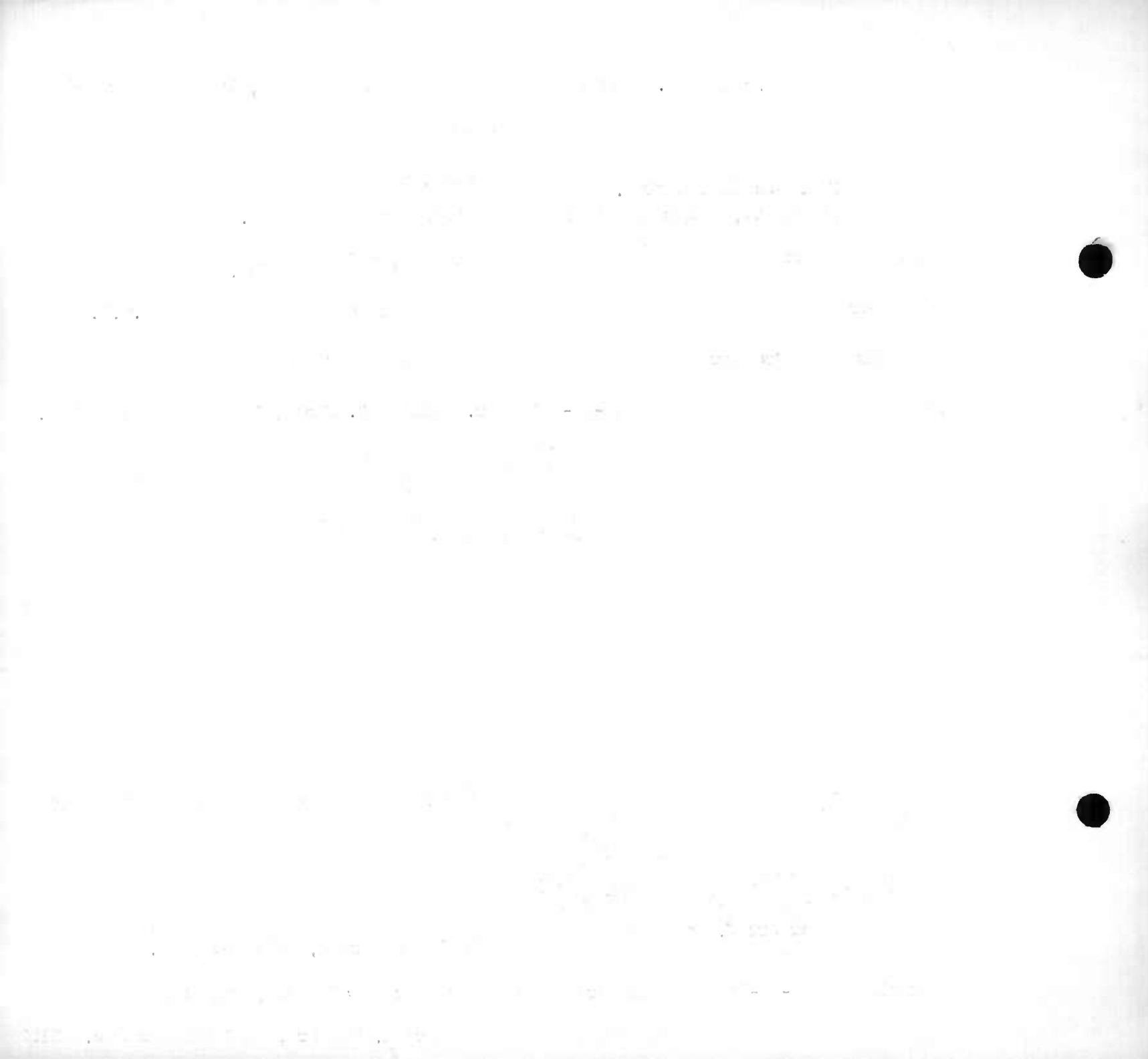
|                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                    |  |                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 56-94-16 djs <u>T-520</u>                                                                                                                                                                                                                                                                                                                                 |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                          |  | 70 7968                                                                                                                                                     |  | X                                                                                  |  | 70 7968                                      |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                 |  | 70 7968                                                                                                   |  | CERTIFICATE OF DEATH                                                                                                                                        |  | REG. NO.                                                                           |  |                                              |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Thomas Anna</u>                                                                                                                                                                                                                                                                                                 |  |                                                                                                           |  | 2. DATE AND HOUR OF DEATH<br><u>Aug 7 1970 106 30 AM</u>                                                                                                    |  |                                                                                    |  |                                              |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                    |  |                                                                                                           |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                       |  |                                                                                    |  |                                              |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Baltimore City Hospitals</u><br><u>4940 Eastern Avenue</u><br><u>Baltimore, Maryland 21224</u>                                                                                                                                                                                                                 |  |                                                                                                           |  | A. STATE<br><u>Maryland</u>                                                                                                                                 |  | B. COUNTY<br><u>Baltimore</u>                                                      |  | C. CITY OR TOWN<br><u>Baltimore</u>          |  |
| D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                             |  |                                                                                                           |  | E. STREET AND NUMBER<br><u>4716 Forest View Road</u>                                                                                                        |  | 21206                                                                              |  |                                              |  |
| 5. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                                   |  | 6. RACE<br><u>White</u>                                                                                   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>1-8-36</u>                                                  |  | 9. AGE (In years last birthday)<br><u>34</u> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>typist clerk</u>                                                                                                                                                                                                                                        |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>newly married</u>                                                 |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                                                                                |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                         |  |                                              |  |
| 13. FATHER'S NAME<br><u>Bernard Schuchman</u>                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |  | 14. MOTHER'S MAIDEN NAME<br><u>Julia Myers</u>                                                                                                              |  |                                                                                    |  |                                              |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>no</u>                                                                                                                                                                                                                                     |  |                                                                                                           |  | 16. SOCIAL SECURITY NO.<br><u>219-32-0231</u>                                                                                                               |  | 17. INFORMANT<br><u>BCH: Records Baltimore, Maryland 21224</u>                     |  |                                              |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>197-81</u>                                                                                                                                       |  |                                                                                                           |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Cardiopulmonary arrest acute</u>                                                                  |  |                                                                                    |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>II</u>                                                                                                                                                                                                               |  |                                                                                                           |  | (B) <u>Suprarenal Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>4 years</u>                                                                        |  |                                                                                    |  | <u>1 week</u>                                |  |
| (C) <u>Thrombophlebitis</u>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                    |  |                                              |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                          |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                    |  |                                              |  |
| 19A. DATE OF OPERATION<br><u>2</u>                                                                                                                                                                                                                                                                                                                        |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20A. AUTOPSY? (Yes or No)<br><u>Yes</u>                                                                                                                     |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><u>Yes</u> |  |                                              |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                         |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                 |  |                                                                                    |  |                                              |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)                                                                                                                                                                                                                                                                                              |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |                                                                                    |  |                                              |  |
| 22. I certify that (X) (this hospital) attended the deceased from <u>May 28</u> 19 <u>70</u> to <u>Aug 7</u> 19 <u>70</u> that (X) (we) last saw the deceased alive on <u>Aug 7</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                    |  |                                              |  |
| 23A. SIGNATURE<br><u>Baine</u>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |  | 23B. DATE SIGNED<br><u>Aug 7 1970</u>                                                                                                                       |  |                                                                                    |  |                                              |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Baine, M.D.</u>                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |  | 23D. ADDRESS<br><u>Baltimore City Hospitals</u><br><u>4940 Eastern Avenue Baltimore, Maryland 21224</u>                                                     |  |                                                                                    |  |                                              |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                 |  | 24B. DATE<br><u>8/10/70</u>                                                                               |  | 24C. NAME of CEMETERY or CREMATORY<br><u>Gardens of Faith</u>                                                                                               |  | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore Md.</u>              |  |                                              |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>AUG 11 1970</u>                                                                                                                                                                                                                                                                                                     |  | 25B. NAME OF REGISTRAR<br><u>Robert E. Faber, M.D.</u>                                                    |  | 25C. FUNERAL DIRECTOR<br><u>Carol D. Lapan</u>                                                                                                              |  | 25D. ADDRESS<br><u>7401 Belair Rd. Balt. Md.</u>                                   |  |                                              |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

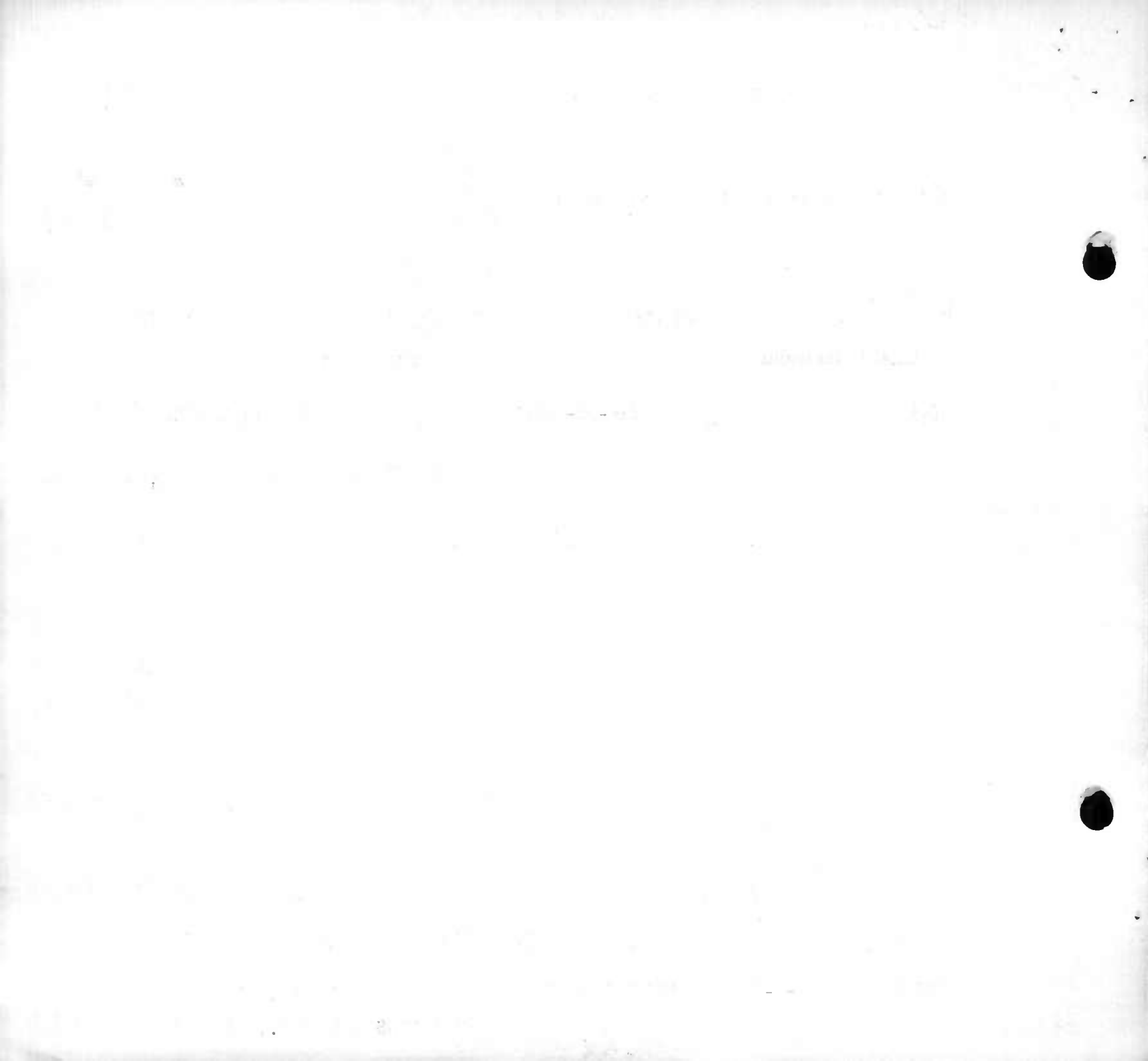
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | REG. NO. <span style="font-size: 1.5em;">70 7969</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>BIRTH NO.</b><br><span style="font-size: 1.5em;">K-410</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | <span style="font-size: 1.5em;">70 7969</span>                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>CERTIFICATE OF DEATH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
| <b>1. NAME OF DECEASED</b><br>(Type or Print) <span style="font-size: 1.2em;">CARRIE M. KLEBE</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                              | <b>2. DATE AND HOUR OF DEATH</b><br><span style="font-size: 1.2em;">August 8, 1970</span>                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br><span style="font-size: 1.2em;">2365 Washington Blvd.<br/>Baltimore, Maryland 21230</span>                                                                                                                                                                                                                                                                               |  |                                                                                                                                                              | <b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission)<br>A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">2553</span><br><br><b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br><br><b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">2365 Washington Blvd.</span> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| <b>5. SEX</b><br><span style="font-size: 1.2em;">Female</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | <b>6. RACE</b><br><span style="font-size: 1.2em;">White</span>                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">Homemaker</span>                                                                                                                                                                                                                                                                                                                                                                                                                |  | <b>10B. KIND OF BUSINESS OR INDUSTRY</b>                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>8. DATE OF BIRTH</b><br><span style="font-size: 1.2em;">April 15, 1901</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
| <b>13. FATHER'S NAME</b><br><span style="font-size: 1.2em;">Frank Granger</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | <b>14. MOTHER'S MAIDEN NAME</b><br><span style="font-size: 1.2em;">Blanche Gassaway</span>                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>9. AGE</b> (In years last birthday)<br><span style="font-size: 1.2em;">69 Yrs.</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">No</span>                                                                                                                                                                                                                                                                                                                                                                                                       |  | <b>16. SOCIAL SECURITY NO.</b><br><span style="font-size: 1.2em;">216-54-0372</span>                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mr. William E. Klebe, 2365 Washington Blvd.</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |
| <b>11. BIRTHPLACE</b> (State or foreign country)<br><span style="font-size: 1.2em;">Maryland</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><span style="font-size: 1.2em;">U.S.A.</span>                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>18. CAUSE OF DEATH</b><br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br><span style="font-size: 1.2em;">Chronic congestive heart failure</span><br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><span style="font-size: 1.2em;">Ischemic heart disease</span><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) INTERMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |  |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| <b>19A. DATE OF OPERATION</b><br><span style="font-size: 1.2em;">0</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>20A. AUTOPSY?</b> (Yes or No)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Indify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| <b>21D. TIME OF INJURY</b> (Approx.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | <b>21E. INJURY OCCURRED</b> White <input type="checkbox"/> Not White <input type="checkbox"/> Walk <input type="checkbox"/> At Work <input type="checkbox"/> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>21F. HOW DID INJURY OCCUR?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| <b>22. I certify that (1) (this hospital) attended the deceased from <span style="font-size: 1.2em;">Feb.</span> 19 <span style="font-size: 1.2em;">64</span> to <span style="font-size: 1.2em;">August 8</span> 19 <span style="font-size: 1.2em;">70</span> that (2) (we) last saw the deceased alive on <span style="font-size: 1.2em;">August 4</span> 19 <span style="font-size: 1.2em;">70</span> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.</b> |  |                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| <b>23A. SIGNATURE</b><br><span style="font-size: 1.2em;">Herbert J. Levickas</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>23B. DATE SIGNED</b><br><span style="font-size: 1.2em;">8/9/70</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
| <b>23C. PHYSICIAN'S NAME</b> (Type)<br><span style="font-size: 1.2em;">Herbert J. Levickas</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | <b>23D. ADDRESS</b><br><span style="font-size: 1.2em;">5404 East Drive, Baltimore, Md. 21227</span>                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br><span style="font-size: 1.2em;">Burial</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | <b>24B. DATE</b><br><span style="font-size: 1.2em;">8-11-1970</span>                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>24C. NAME OF CEMETERY OR CREMATORY</b><br><span style="font-size: 1.2em;">Baltimore National Cemetery</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br><span style="font-size: 1.2em;">Baltimore, Maryland</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><span style="font-size: 1.2em;">AUG 11 1970</span>                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| <b>25B. NAME OF REGISTRAR</b><br><span style="font-size: 1.2em;">Robert E. Farber, M.D.</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | <b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Howard H. Hubbard, 4107 Wilkens Ave. 21229</span>                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

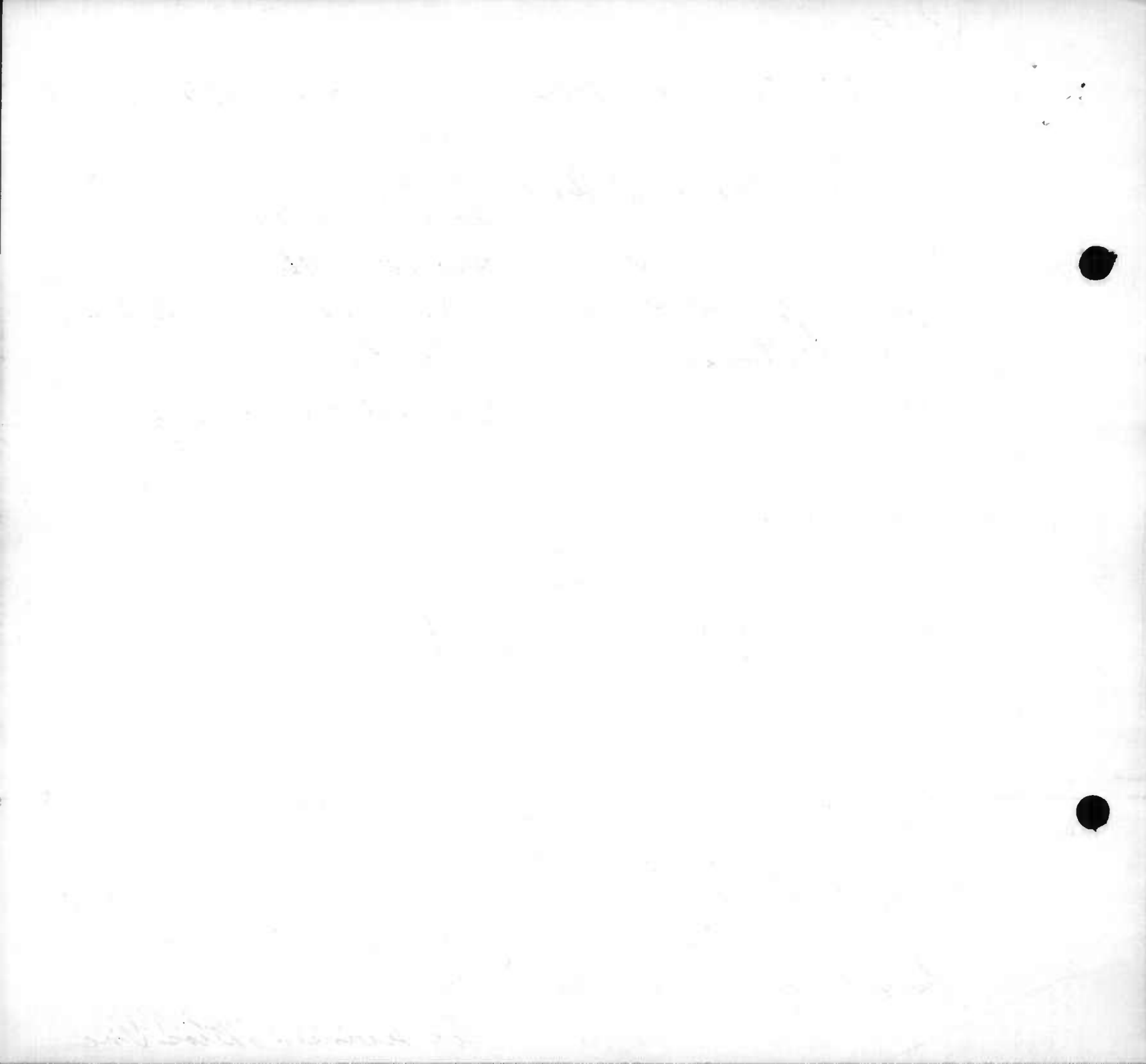
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                  |  | CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                             |  | REG. NO. <u>70 7970</u>                                                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|
| <b>BIRTH NO.</b><br><u>H-142</u>                                                                                                                                                                                                                                                                                                                                                                                                          |  | <b>70 7970</b>                                                                                                   |  | <b>2. DATE AND HOUR OF DEATH</b><br><u>8/7/70</u> <u>19PM</u>                                                                                                                                                                                                                                                                                                                    |  | <b>1. NAME OF DECEASED</b><br>(Type or Print) <u>Clara Havelock</u>                        |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>SINAI HOSPITAL OF BALTIMORE</u>                                                                                                                                                                                                               |  |                                                                                                                  |  | <b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>Balto.</u><br><b>C. CITY OR TOWN</b> <u>BALTIMORE</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/><br><b>E. STREET AND NUMBER</b> <u>3429 Ripple Road Balto. Md. 21207</u> |  |                                                                                            |  |
| <b>5. SEX</b><br><u>Female</u>                                                                                                                                                                                                                                                                                                                                                                                                            |  | <b>6. RACE</b><br><u>White</u>                                                                                   |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>                                                                                                                                                                                                 |  | <b>8. DATE OF BIRTH</b><br><u>10/20/98</u>                                                 |  |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                                                                                                                                                                                                                                                                                    |  | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><u>AT HOME</u>                                                       |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Russia</u>                                                                                                                                                                                                                                                                                                                |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA</u>                                          |  |
| <b>13. FATHER'S NAME</b><br><u>LAIB VAIDERGORN</u>                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>IEAH ?</u>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                            |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>                                                                                                                                                                                                                                                                                                           |  | <b>16. SOCIAL SECURITY NO.</b><br><u>216-32-7206B</u>                                                            |  | <b>17. INFORMANT</b> <u>Daughter - SARAH Lee</u> <b>ADDRESS</b> <u>ANSHEL SAME</u>                                                                                                                                                                                                                                                                                               |  |                                                                                            |  |
| <b>18. CAUSE OF DEATH</b><br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>Heart FAILURE</u><br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>DIABETIS &amp; Hypertension</u> |  |                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                  |  | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><u>12 hours</u><br><u>10 years.</u> |  |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                            |  |
| <b>19A. DATE OF OPERATION</b><br><u>8/7</u>                                                                                                                                                                                                                                                                                                                                                                                               |  | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b><br><u>8/13</u>                                           |  | <b>20A. AUTOPSY?</b> (Yes or No) <u>NO</u>                                                                                                                                                                                                                                                                                                                                       |  | <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>                |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                     |  | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)                                                                                                                                                                                                                                                                                                  |  |                                                                                            |  |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                          |  | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | <b>21F. HOW DID INJURY OCCUR?</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                            |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from <u>8/7</u> <u>8/13</u> <u>1970</u> to <u>8/7</u> <u>1970</u> that (I) (we) last saw the deceased alive on <u>8/7</u> <u>1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>                                                                        |  |                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                            |  |
| <b>23A. SIGNATURE</b><br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                  |  | <b>23B. DATE SIGNED</b><br><u>8.7. 1970</u>                                                                                                                                                                                                                                                                                                                                      |  | <b>23C. PHYSICIAN'S NAME</b> (Type)<br><u>CARLOS VICTOR ROZENBOM</u>                       |  |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br><u>BURIAL</u>                                                                                                                                                                                                                                                                                                                                                                          |  | <b>24B. DATE</b><br><u>8-9-70</u>                                                                                |  | <b>24C. NAME of CEMETERY or CREMATORY</b><br><u>LUBAWITZ NUSI ARI</u>                                                                                                                                                                                                                                                                                                            |  | <b>24D. LOCATION</b> (City, town, or county) (State)<br><u>ROSEDALE, MARYLAND</u>          |  |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><u>AUG 11 1970</u>                                                                                                                                                                                                                                                                                                                                                                              |  | <b>25B. NAME OF REGISTRAR</b><br><u>[Signature]</u>                                                              |  | <b>25C. FUNERAL DIRECTOR</b> <u>SOL LEVINSON &amp; BROS.</u> <b>ADDRESS</b> <u>6010 REISTERSTOWN ROAD</u>                                                                                                                                                                                                                                                                        |  |                                                                                            |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                     |  |                             |  |                                                                                                                                                             |  |                                                                                                                                     |  |                                                                          |                                                                                               |                                                                                    |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--|
| REG. NO. 70 7971                                                                                                                                                                                                                                                                                                                                     |  |                             |  |                                                                                                                                                             |  |                                                                                                                                     |  |                                                                          |                                                                                               |                                                                                    |  |
| X-451 70 7971                                                                                                                                                                                                                                                                                                                                        |  |                             |  |                                                                                                                                                             |  |                                                                                                                                     |  |                                                                          |                                                                                               |                                                                                    |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Minnie KAHLENBERG</i>                                                                                                                                                                                                                                                                                      |  |                             |  |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br><i>8-9-1970 1:03 A.M.</i>                                                                              |  |                                                                          |                                                                                               |                                                                                    |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><i>91 Leivindale Aged Home</i>                                                                                                                                                                                                                                                             |  |                             |  |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>Md</i> B. COUNTY <i>Balto.</i> |  |                                                                          |                                                                                               |                                                                                    |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>91 Leivindale Aged Home</i>                                                                                                                                                                                                          |  |                             |  |                                                                                                                                                             |  | C. CITY OR TOWN<br><i>Baltimore</i>                                                                                                 |  |                                                                          | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                    |  |
| E. STREET AND NUMBER<br><i>2413 Diana Rd.</i>                                                                                                                                                                                                                                                                                                        |  |                             |  |                                                                                                                                                             |  |                                                                                                                                     |  |                                                                          |                                                                                               |                                                                                    |  |
| 5. SEX<br><i>FEMALE</i>                                                                                                                                                                                                                                                                                                                              |  | 6. RACE<br><i>CAUCASIAN</i> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><i>76</i>                                                                                                       |  | 9. AGE (in years last birthday)<br><i>76</i>                             |                                                                                               | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                         |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>                                                                                                                                                                                                                                      |  |                             |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>At Home</i>                                                                                                         |  |                                                                                                                                     |  | 11. BIRTHPLACE (State or foreign country)<br><i>AUSTRIA</i>              |                                                                                               | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                      |  |
| 13. FATHER'S NAME<br><i>Hertman</i>                                                                                                                                                                                                                                                                                                                  |  |                             |  |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br><i>Unknown</i>                                                                                          |  |                                                                          |                                                                                               |                                                                                    |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>NO</i>                                                                                                                                                                                                                                |  |                             |  |                                                                                                                                                             |  | 16. SOCIAL SECURITY NO.                                                                                                             |  | 17. INFORMANT<br><i>Bernard Kahlenberg - Same</i>                        |                                                                                               |                                                                                    |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><i>ARTERIOSCLEROTIC HEART DISEASE</i>                                                                                                           |  |                             |  |                                                                                                                                                             |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><i>ARTERIOSCLEROTIC HEART DISEASE</i>                      |  |                                                                          |                                                                                               |                                                                                    |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><i>FIBROSIS RIGHT LUNG PROBABLY SECONDARY TO RENOVATION</i>                                                                                                                                                        |  |                             |  |                                                                                                                                                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>YEARS</i>                                                                        |  |                                                                          |                                                                                               |                                                                                    |  |
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                |  |                             |  |                                                                                                                                                             |  |                                                                                                                                     |  |                                                                          |                                                                                               |                                                                                    |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                     |  |                             |  |                                                                                                                                                             |  |                                                                                                                                     |  |                                                                          |                                                                                               |                                                                                    |  |
| 19A. DATE OF OPERATION<br><i>0</i>                                                                                                                                                                                                                                                                                                                   |  |                             |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                                                                     |  | 20A. AUTOPSY? (Yes or No)<br><i>yes</i>                                  |                                                                                               | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><i>yes</i> |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                              |  |                             |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  |                                                                                                                                     |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                                                               |                                                                                    |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                            |  |                             |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                      |  |                                                                                                                                     |  | 21F. HOW DID INJURY OCCUR?                                               |                                                                                               |                                                                                    |  |
| 22. I certify that (1) (this hospital) attended the deceased from <i>12-26</i> 19 <i>66</i> to <i>8-9</i> 19 <i>70</i> that (1) (we) last saw the deceased alive on <i>8-8</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                             |  |                                                                                                                                                             |  |                                                                                                                                     |  |                                                                          |                                                                                               |                                                                                    |  |
| 23A. SIGNATURE<br><i>Theodore R. Reiff MD</i>                                                                                                                                                                                                                                                                                                        |  |                             |  |                                                                                                                                                             |  | Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>     |  | 23B. DATE SIGNED<br><i>8-9-1970</i>                                      |                                                                                               |                                                                                    |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>THEODORE R. REIFF MD</i>                                                                                                                                                                                                                                                                                          |  |                             |  |                                                                                                                                                             |  | 23D. ADDRESS<br><i>Leivindale Aged Home</i>                                                                                         |  |                                                                          |                                                                                               |                                                                                    |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                             |  | 24B. DATE<br><i>8/10/70</i> |  | 24C. NAME of CEMETERY or CREMATORY<br><i>Mount Sharon Cemetery</i>                                                                                          |  |                                                                                                                                     |  | 24D. LOCATION (City, town, or county) (State)<br><i>Phila. Pa</i>        |                                                                                               |                                                                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>AUG 11 1970</i>                                                                                                                                                                                                                                                                                                |  |                             |  | 25B. NAME OF REGISTRAR<br><i>Robert E. Fisher</i>                                                                                                           |  |                                                                                                                                     |  | 25C. FUNERAL DIRECTOR<br><i>Ed Turner &amp; Sons Inc</i>                 |                                                                                               |                                                                                    |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                           |  |                                                                                                           |  | X                                                                                                                                                           |  | 70 7972                                                                                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------|--|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                       |  |                                                                                                           |  | BIRTH NO.                                                                                                                                                   |  | 70 7972                                                                                                              |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Lillian Uebel</u>                                                                                                                                                                                                                                                                |  |                                                                                                           |  | 2. DATE AND HOUR OF DEATH<br><u>8/7/1970</u> <u>11:55 P.M.</u>                                                                                              |  |                                                                                                                      |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><u>Lutheran Hospital</u>                                                                                                                                                                                                                                         |  |                                                                                                           |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>                |  |                                                                                                                      |  |
| FULL NAME OF HOSPITAL OR INSTITUTION                                                                                                                                                                                                                                                                                       |  | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION                                        |  | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                         |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                   |  |
| 5. SEX<br><u>F</u>                                                                                                                                                                                                                                                                                                         |  | 6. RACE<br><u>W</u>                                                                                       |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>6-12-08</u>                                                                                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                                                                                                                                                                            |  | 10B. KIND OF BUSINESS OR INDUSTRY                                                                         |  | 9. AGE (in years last birthday)<br><u>62</u>                                                                                                                |  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                                                               |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                                                                                                                                                                                                                                               |  |                                                                                                           |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                                                  |  |                                                                                                                      |  |
| 13. FATHER'S NAME<br><u>William A. Owens</u>                                                                                                                                                                                                                                                                               |  |                                                                                                           |  | 14. MOTHER'S MAIDEN NAME<br><u>Selma Eversmeier</u>                                                                                                         |  |                                                                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                      |  | 16. SOCIAL SECURITY NO.                                                                                   |  | 17. INFORMANT<br><u>CHART</u>                                                                                                                               |  | ADDRESS                                                                                                              |  |
| 18. <u>5-26-01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>HEPATIC FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>STRICTURE COMMON BILE DUCT</u>        |  |                                                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |  |                                                                                                                      |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>II</u>                                                                                                                                                                                |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                      |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                           |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                      |  |
| 19A. DATE OF OPERATION<br><u>7/16/1970</u>                                                                                                                                                                                                                                                                                 |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Stricture Common Bile Duct</u>                     |  | 20A. AUTOPSY? (Yes or No)<br><u>No</u>                                                                                                                      |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                 |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                          |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |  |                                                                                                                      |  |
| 21D. TIME OF INJURY (APPROX.)<br><u>—</u>                                                                                                                                                                                                                                                                                  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |                                                                                                                      |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6/4/1970</u> to <u>8/7/1970</u> that (I) (we) last saw the deceased alive on <u>8/7/1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                      |  |
| 23A. SIGNATURE<br><u>S. Basu</u>                                                                                                                                                                                                                                                                                           |  |                                                                                                           |  | 23B. DATE SIGNED<br><u>8/7/1970</u>                                                                                                                         |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>S. BASU</u>                                                                                                                                                                                                                                                                             |  |                                                                                                           |  | 23D. ADDRESS<br><u>Lutheran Hospital of Maryland</u>                                                                                                        |  |                                                                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                  |  | 24B. DATE<br><u>8/11/70</u>                                                                               |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Meadowridge Cemetery</u>                                                                                           |  | 24D. LOCATION (City, town, or county) (State)<br><u>Eekridge - Howard Co. - Md</u>                                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>AUG 11 1970</u>                                                                                                                                                                                                                                                                      |  | 25B. NAME OF REGISTRAR<br><u>R. B. E. J. B. JR.</u>                                                       |  | 25C. FUNERAL DIRECTOR<br><u>E. S. Mac Nabb - 301 Frederick Rd - 21228</u>                                                                                   |  |                                                                                                                      |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                         |              |                                                                                                                                                             |                                  | REG. NO. 70 7973                                                                              |                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------|
| K-656 70 7973                                                                                                                                                                                                                                                                                                            |              | BIRTH NO.                                                                                                                                                   |                                  |                                                                                               |                                                        |
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                   |              | 2. DATE AND HOUR OF DEATH                                                                                                                                   |                                  |                                                                                               |                                                        |
| KRAMER, ELLA MAY                                                                                                                                                                                                                                                                                                         |              | Aug 5, 1970 11 A.M.                                                                                                                                         |                                  |                                                                                               |                                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                   |              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                                                       |                                  |                                                                                               |                                                        |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>The Union Memorial Hospital                                                                                                                                                                                                                                                      |              | A. STATE<br>Maryland                                                                                                                                        |                                  | B. COUNTY                                                                                     |                                                        |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                     |              | C. CITY OR TOWN<br>Baltimore                                                                                                                                |                                  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                        |
| 44                                                                                                                                                                                                                                                                                                                       |              | E. STREET AND NUMBER<br>5522 Plainfield Ave.                                                                                                                |                                  |                                                                                               |                                                        |
| 5. SEX<br>F                                                                                                                                                                                                                                                                                                              | 6. RACE<br>W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>June 3, 1900 | 9. AGE (In years last birthday)<br>70                                                         | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife SEAMSTRESS                                                                                                                                                                                                      |              | 10B. KIND OF BUSINESS OR INDUSTRY<br>CLOTHING FACTORY                                                                                                       |                                  | 11. BIRTHPLACE (State or foreign country)<br>Baltimore Maryland                               |                                                        |
| 13. FATHER'S NAME<br>SAMUEL BERRY                                                                                                                                                                                                                                                                                        |              | 14. MOTHER'S MAIDEN NAME<br><del>UNKNOWN</del> ADELINE DAVIS                                                                                                |                                  | 12. CITIZEN OF WHAT COUNTRY<br>U.S.                                                           |                                                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                           |              | 16. SOCIAL SECURITY NO.<br>217-01-0161                                                                                                                      |                                  | 17. INFORMANT<br>Mr. Howard White                                                             |                                                        |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Intercerebral hemorrhage                                                                                           |              | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:      |                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |                                                        |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                           |              |                                                                                                                                                             |                                  |                                                                                               |                                                        |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                   |              |                                                                                                                                                             |                                  |                                                                                               |                                                        |
| 19A. DATE OF OPERATION<br>2                                                                                                                                                                                                                                                                                              |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                  | 20A. AUTOPSY? (Yes or No)<br>Yes                                                              |                                                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                    |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |                                                        |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                             |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                  | 21F. HOW DID INJURY OCCUR?                                                                    |                                                        |
| 22. I certify that (I) (this hospital) attended the deceased from 6:45 am, 8-5-1970 to 11:00 am, 8-5-1970 that (I) (we) last saw the deceased alive on 8-5-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |              |                                                                                                                                                             |                                  |                                                                                               |                                                        |
| 23A. SIGNATURE<br>John Ohe M.D.                                                                                                                                                                                                                                                                                          |              | 23B. DATE SIGNED<br>8-5-70                                                                                                                                  |                                  |                                                                                               |                                                        |
| 23C. PHYSICIAN'S NAME (Type)<br>Tohru Ohe M.D.                                                                                                                                                                                                                                                                           |              | 23D. ADDRESS<br>221 East 33rd st, Baltimore                                                                                                                 |                                  |                                                                                               |                                                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                                                                                                                                                                                                       |              | 24B. DATE<br>8-10-1970                                                                                                                                      |                                  | 24C. NAME of CEMETERY or CREMATORY<br>BALTO. U.S. NATIONAL                                    |                                                        |
| 24D. LOCATION<br>5501 FREDERICK Rd. BALTO. Md.                                                                                                                                                                                                                                                                           |              |                                                                                                                                                             |                                  |                                                                                               |                                                        |
| 25A. DATE REC'D BY HEALTH DEPT.<br>AUG 11 1970                                                                                                                                                                                                                                                                           |              | 25B. NAME OF REGISTRAR<br>Robert E. Fisher, Md.                                                                                                             |                                  | 25C. FUNERAL DIRECTOR<br>J. Walter Conklin 5444 BELAIR Rd.                                    |                                                        |

Released by Medical Examiner 12-20-PM 8-5-70



S-545

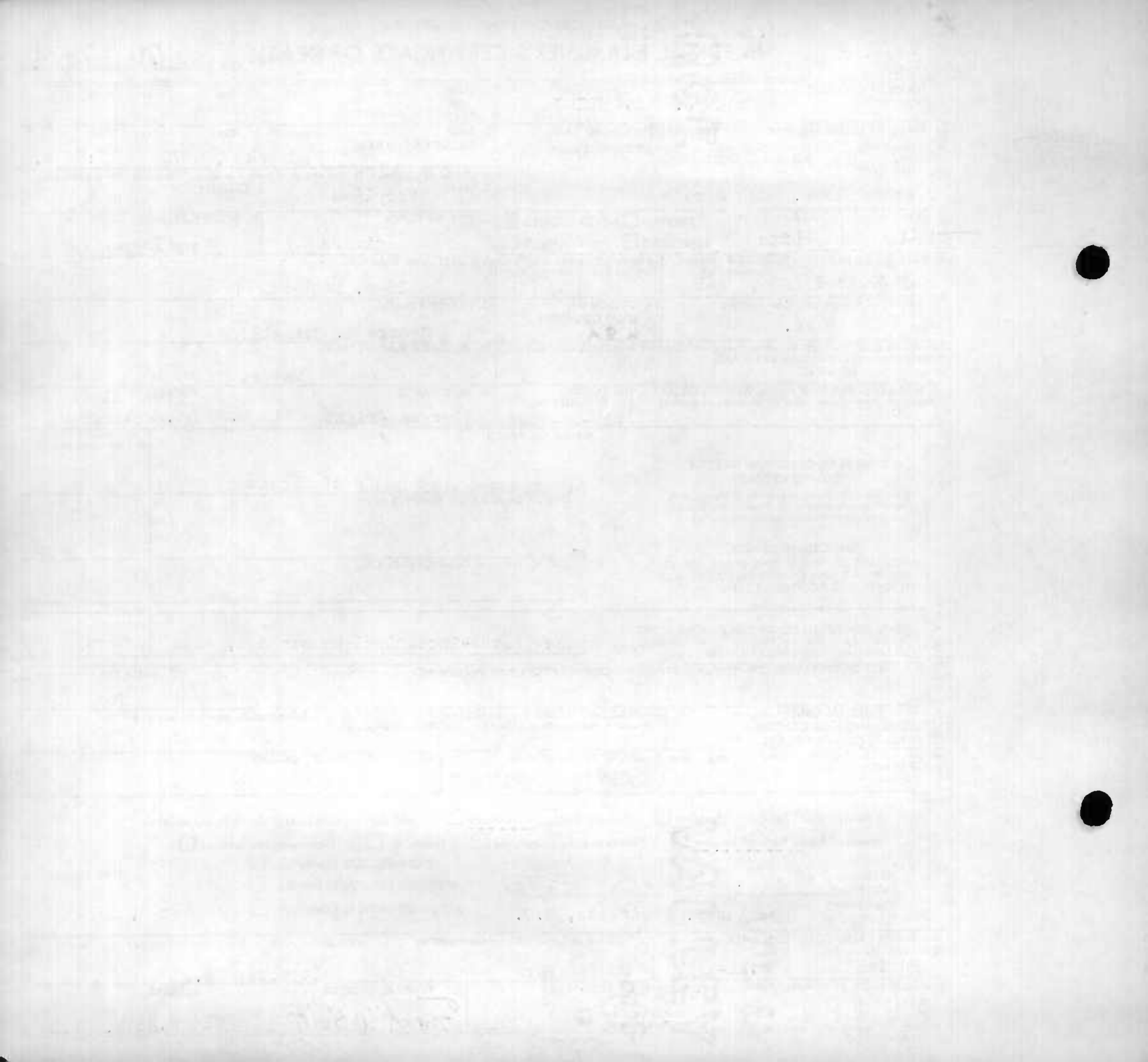
70 7974 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7974

BIRTH NO.

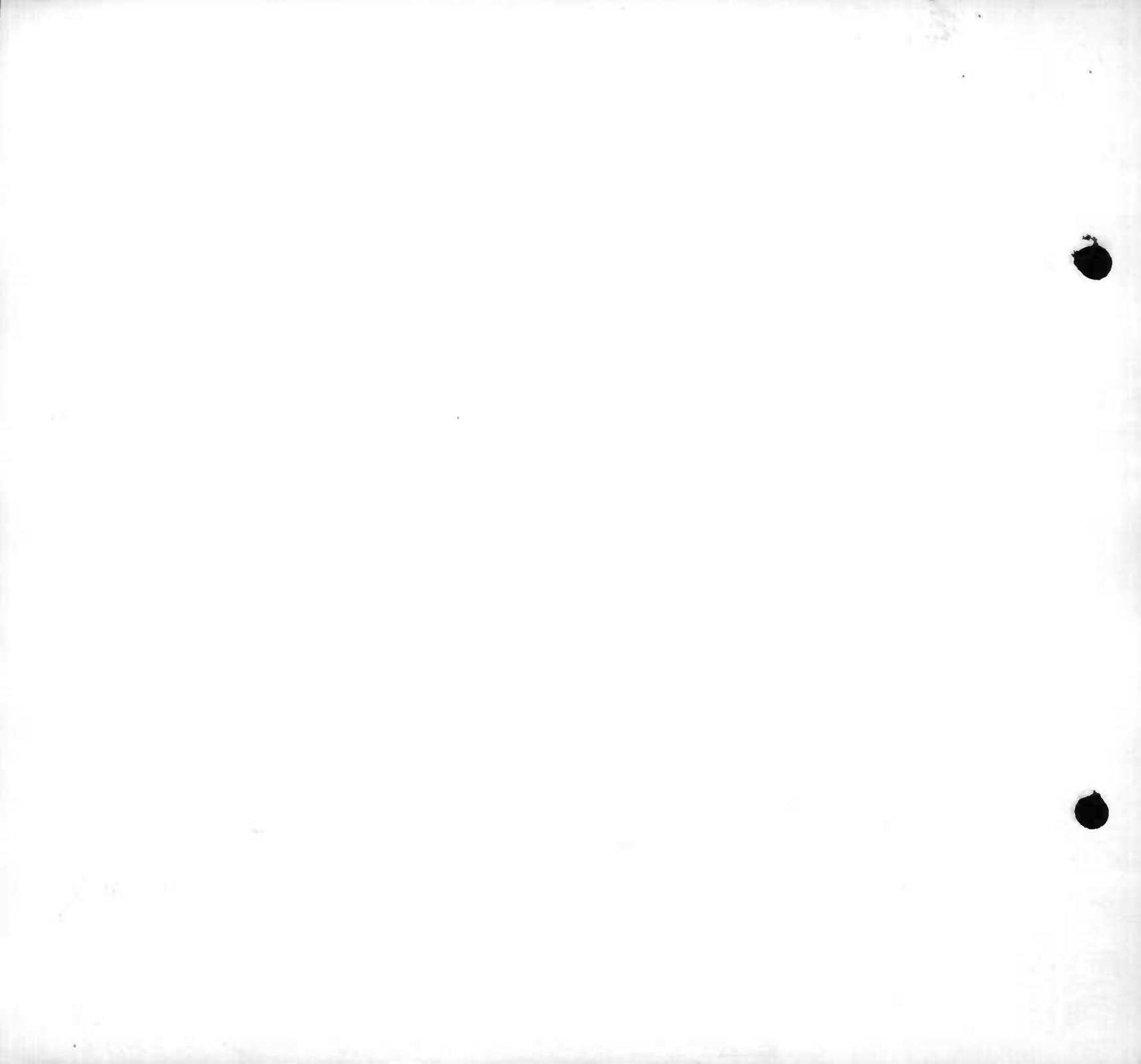
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                           |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | EDWARD J. SCHNEHLING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.           |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>August 8, 1970 5:45 A.M.                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY 1307 |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>00 915 W. 38th Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 6. SEX Male 7. RACE White 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                             |  | C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  |
| 9. DATE OF BIRTH May 30, 1909                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10. AGE (In years lost birthday) 61                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | E. STREET AND NUMBER 915 W. 38th Street                                                                                   |  |
| 11. BIRTHPLACE (State or foreign country) Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 13. FATHER'S NAME George H. Schmebling                                                                                    |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME Meyers                                                                                           |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 17. SOCIAL SECURITY NO. 217-05-9422                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 18. INFORMANT ADDRESS 21211 Theresa Wright 915 W. 38 St. Baltimore                                                        |  |
| 19. 5-71.01 CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>Acute gastro-intestinal hemorrhage, site unknown |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                              |  |
| 20A. DATE OF OPERATION 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 21. AUTOPSY? (Yes or No) Yes                                                                                              |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?                                                  |  |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 22F. HOW DID INJURY OCCUR?                                                                                                |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED August 8, 1970<br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                           |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 24B. DATE 8.11-1970                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 24C. NAME of CEMETERY or CREMATORY Loudon Park                                                                            |  |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 25A. DATE REC'D BY HEALTH DEPT. AUG 11 1970                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D.                                                                             |  |
| 25C. FUNERAL DIRECTOR Frank W. Seitz                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | ADDRESS 814 W. 36th St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                           |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

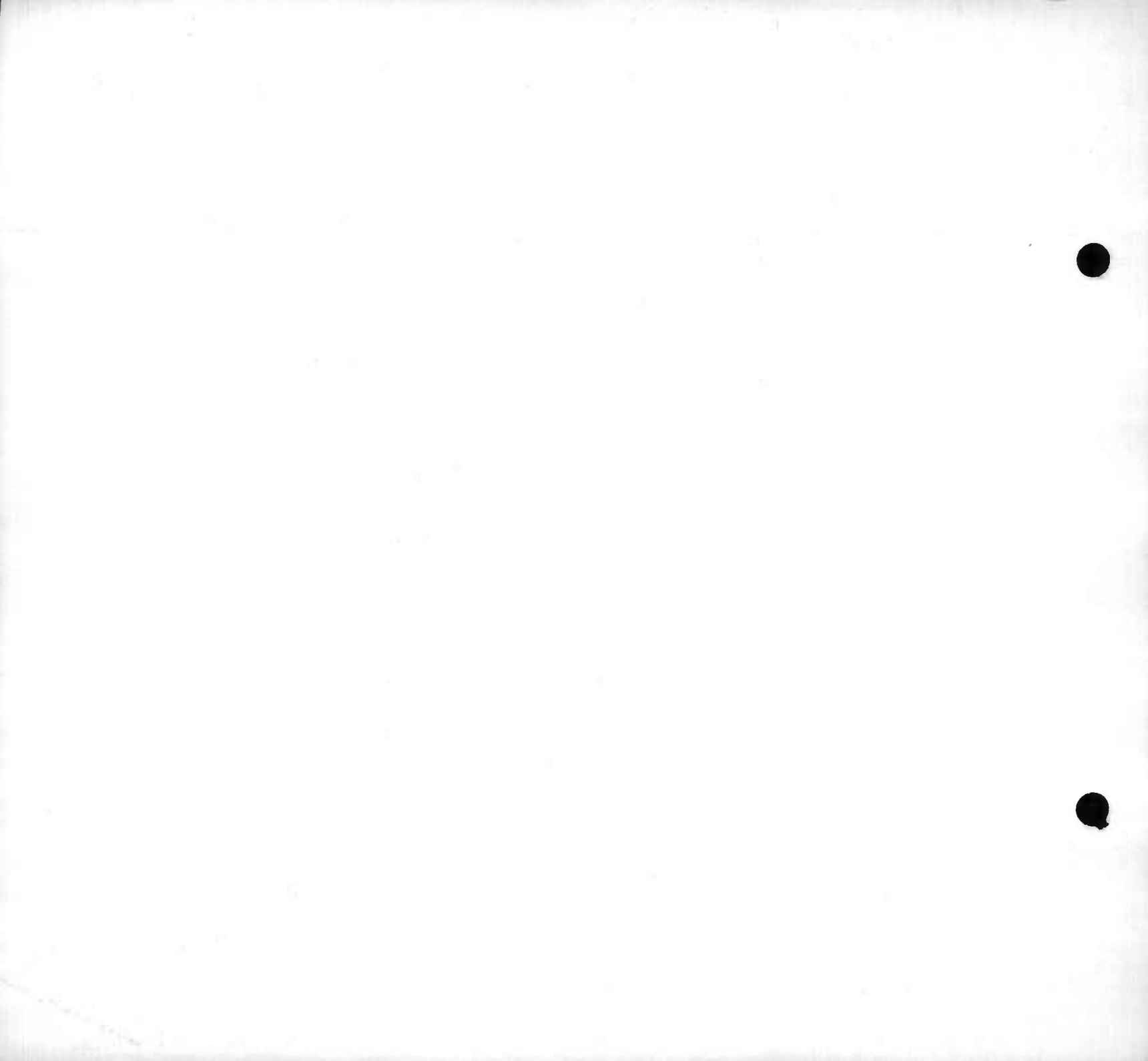
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                   |  |                         |  |                                                                                                                                                             |                                                                                                                                              |                                     |  |                                              |  |                                                                                               |  |                              |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--|----------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|------------------------------|--|--|
| 70 7975 CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                       |  |                         |  |                                                                                                                                                             | REG. NO. 70 7975                                                                                                                             |                                     |  |                                              |  |                                                                                               |  |                              |  |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                          |  |                         |  |                                                                                                                                                             | 1. NAME OF DECEASED<br>(Type or Print) <i>Mr. JOHN LIBERTO</i>                                                                               |                                     |  |                                              |  | 2. DATE AND HOUR OF DEATH<br><i>8/9/70 4:30 p.m.</i>                                          |  |                              |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                             |  |                         |  |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> |                                     |  |                                              |  | 5.300                                                                                         |  |                              |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>34 BonSecours Hospital</i>                                                                                                                                                                                                                                                                                                                                              |  |                         |  |                                                                                                                                                             | C. CITY OR TOWN<br><i>Baltimore</i>                                                                                                          |                                     |  |                                              |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                              |  |  |
| E. STREET AND NUMBER<br><i>712 Templecliff Road</i>                                                                                                                                                                                                                                                                                                                                                                |  |                         |  |                                                                                                                                                             |                                                                                                                                              |                                     |  |                                              |  |                                                                                               |  |                              |  |  |
| 5. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                                                              |  | 6. RACE<br><i>White</i> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                              | 8. DATE OF BIRTH<br><i>10/13/10</i> |  | 9. AGE (in years last birthday)<br><i>59</i> |  | 10. Under 1 Yr. Months Days                                                                   |  | 11. Under 24 Hrs. Hours Min. |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Retired</i>                                                                                                                                                                                                                                                                                                      |  |                         |  |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>-</i>                                                                                                |                                     |  |                                              |  | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>                                  |  |                              |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                                                                                                                                                                                                                                                                                                      |  |                         |  |                                                                                                                                                             | 13. FATHER'S NAME<br><i>Samuel Liberto</i>                                                                                                   |                                     |  |                                              |  | 14. MOTHER'S MAIDEN NAME<br><i>Rosalie Liberto</i>                                            |  |                              |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                           |  |                         |  |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><i>217-32-9686</i>                                                                                                |                                     |  |                                              |  | 17. INFORMANT<br><i>Mrs. Virginia Liberto, 712 Templecliff Rd., Baltimore, Md. 21208</i>      |  |                              |  |  |
| 18. <i>398X I</i> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                   |  |                         |  |                                                                                                                                                             |                                                                                                                                              |                                     |  |                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                  |  |                              |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><i>Cardiac failure</i>                                                                                                                                                                                           |  |                         |  |                                                                                                                                                             |                                                                                                                                              |                                     |  |                                              |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                           |  |                              |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><i>Rheumatic heart disease</i>                                                                                                                                                                                                                                                   |  |                         |  |                                                                                                                                                             |                                                                                                                                              |                                     |  |                                              |  | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                           |  |                              |  |  |
| (C) <i>-</i>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                         |  |                                                                                                                                                             |                                                                                                                                              |                                     |  |                                              |  |                                                                                               |  |                              |  |  |
| II                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                         |  |                                                                                                                                                             |                                                                                                                                              |                                     |  |                                              |  |                                                                                               |  |                              |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                   |  |                         |  |                                                                                                                                                             |                                                                                                                                              |                                     |  |                                              |  |                                                                                               |  |                              |  |  |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                             |  |                         |  |                                                                                                                                                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                             |                                     |  |                                              |  | 20A. AUTOPSY? (Yes or No)<br><i>No</i>                                                        |  |                              |  |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                               |  |                         |  |                                                                                                                                                             |                                                                                                                                              |                                     |  |                                              |  |                                                                                               |  |                              |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                     |  |                         |  |                                                                                                                                                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                     |                                     |  |                                              |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |                              |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                          |  |                         |  |                                                                                                                                                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                       |                                     |  |                                              |  | 21F. HOW DID INJURY OCCUR?                                                                    |  |                              |  |  |
| 22. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <i>8/03/70</i> 19 <i>70</i> to <i>8/9</i> 19 <i>70</i> that (I) ( <del>we</del> ) last saw the deceased alive on <i>8/9</i> 19 <i>70</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) ( <del>not</del> ) view the body after death. |  |                         |  |                                                                                                                                                             |                                                                                                                                              |                                     |  |                                              |  |                                                                                               |  |                              |  |  |
| 23A. SIGNATURE<br><i>Kusuma K. Pruksapong M.D.</i>                                                                                                                                                                                                                                                                                                                                                                 |  |                         |  |                                                                                                                                                             |                                                                                                                                              |                                     |  |                                              |  | 23B. DATE SIGNED<br><i>8/9/70</i>                                                             |  |                              |  |  |
| 23C. PHYSICIAN'S NAME (Type) <i>KUSUMA K. PRUKSAPONG M.D.</i>                                                                                                                                                                                                                                                                                                                                                      |  |                         |  |                                                                                                                                                             |                                                                                                                                              |                                     |  |                                              |  | 23D. ADDRESS<br><i>Bon Secours Hospital</i>                                                   |  |                              |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                                          |  |                         |  |                                                                                                                                                             | 24B. DATE<br><i>8/13/70</i>                                                                                                                  |                                     |  |                                              |  | 24C. NAME OF CEMETERY or CREMATORY<br><i>New Cathedral Cemetery</i>                           |  |                              |  |  |
| 24D. LOCATION<br><i>Baltimore, Maryland</i>                                                                                                                                                                                                                                                                                                                                                                        |  |                         |  |                                                                                                                                                             |                                                                                                                                              |                                     |  |                                              |  |                                                                                               |  |                              |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>AUG 11 1970</i>                                                                                                                                                                                                                                                                                                                                                              |  |                         |  |                                                                                                                                                             | 25B. NAME OF REGISTRAR<br><i>Robert E. Taylor, Jr.</i>                                                                                       |                                     |  |                                              |  | 25C. FUNERAL DIRECTOR<br><i>Witzke, 1630 Edmondson Av., Baltimore, Md.</i>                    |  |                              |  |  |
| 25D. ADDRESS<br><i>21228</i>                                                                                                                                                                                                                                                                                                                                                                                       |  |                         |  |                                                                                                                                                             |                                                                                                                                              |                                     |  |                                              |  |                                                                                               |  |                              |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

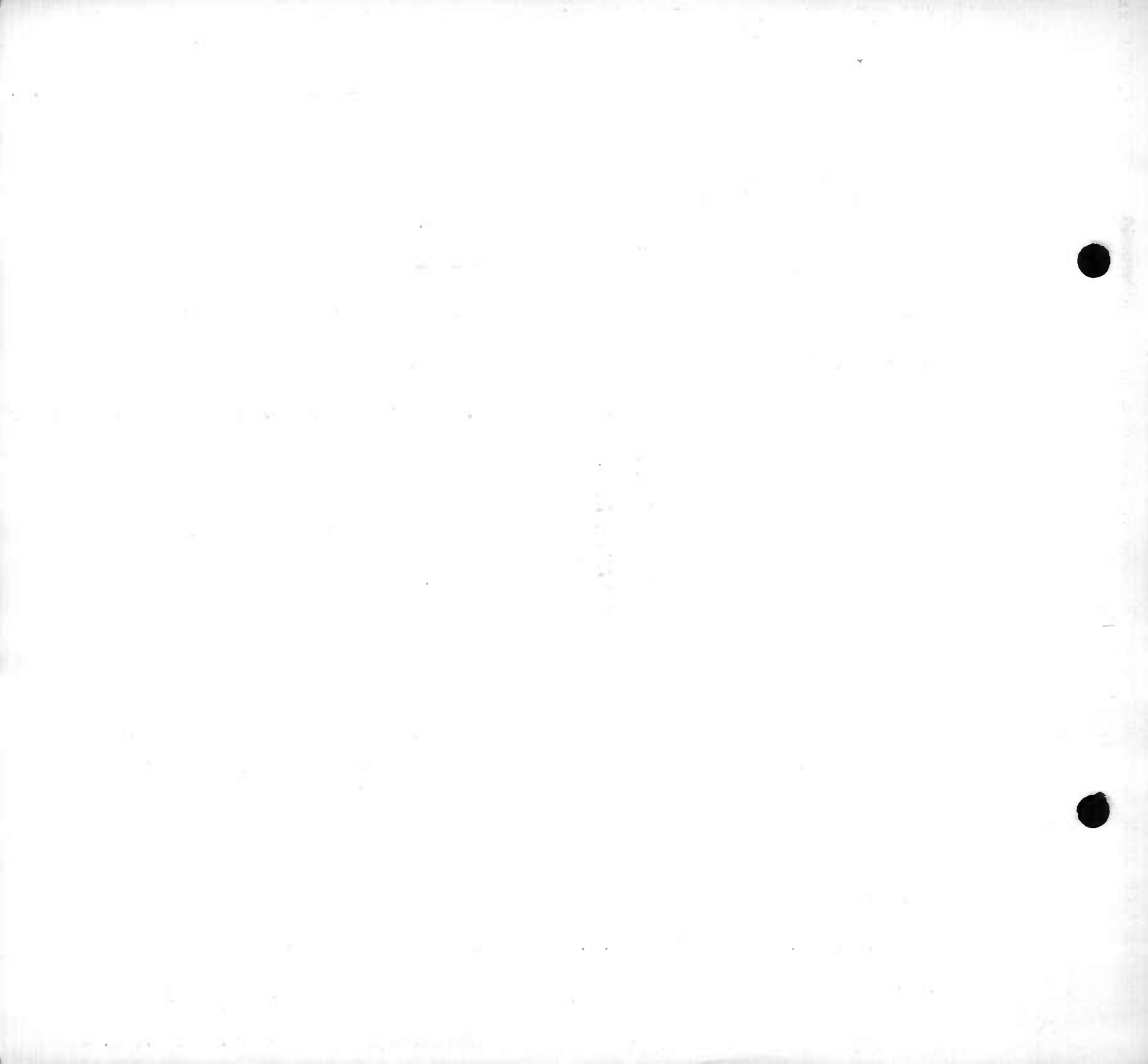
| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                             |                                                                                                           |                                                                                                                                                                                       |                                                                               | REG. NO. <u>70 7976</u>                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| B-630 70 7976<br>10-14263                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                                                       |                                                                               |                                                                                    |
| 1. NAME OF DECEASED<br>(Type or Print) <u>BABY BOY BYRD (mother)</u>                                                                                                                                                                                                                                                                                 |                                                                                                           | 2. DATE AND HOUR OF DEATH<br><u>8-9-70 8:30 A.M.</u>                                                                                                                                  |                                                                               |                                                                                    |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                               |                                                                                                           | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>1538</u>                                               |                                                                               |                                                                                    |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>JOHNS HOPKINS HOSPITAL</u><br><u>33</u>                                                                                                                                                                                                                                                                   |                                                                                                           | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                                                   |                                                                               | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                 |                                                                                                           | E. STREET AND NUMBER<br><u>3703 Forest Park Avenue 21216</u>                                                                                                                          |                                                                               |                                                                                    |
| 5. SEX<br><u>M</u>                                                                                                                                                                                                                                                                                                                                   | 6. RACE<br><u>N</u>                                                                                       | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                           | 8. DATE OF BIRTH<br><u>8/8/70</u>                                             | 9. AGE (in years last birthday)<br><u>24</u>                                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>NEWBORN</u>                                                                                                                                                                                                                                        |                                                                                                           | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>NEWBORN</u>                                                                                                                                   |                                                                               | 11. BIRTHPLACE (State or foreign country)                                          |
| 13. FATHER'S NAME<br><u>Rodney Byrd</u>                                                                                                                                                                                                                                                                                                              |                                                                                                           | 14. MOTHER'S MAIDEN NAME<br><u>Clarestine Bell</u>                                                                                                                                    |                                                                               |                                                                                    |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>                                                                                                                                                                                                                                |                                                                                                           | 16. SOCIAL SECURITY NO.<br><u>NONE</u>                                                                                                                                                |                                                                               | 17. INFORMANT ADDRESS                                                              |
| 18. <u>776.11</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                                                                                                           | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <u>HYALINE MEMBRANE DIS.</u> 8 HRS<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <u>PREMATURITY</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                                                                               |                                                                                    |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                               |                                                                                                           | <u>POSSIBLE INTRAUTERINE SEPSIS</u>                                                                                                                                                   |                                                                               |                                                                                    |
| 19A. DATE OF OPERATION<br><u>2</u> <u>NONE</u>                                                                                                                                                                                                                                                                                                       | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>_____                                                 | 20A. AUTOPSY? (Yes or No)<br><u>Yes</u>                                                                                                                                               | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>_____ |                                                                                    |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><u>NONE</u>                                                                                                                                                                                                                                                 | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><u>NONE</u>   | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)<br>_____                                                                                                  |                                                                               |                                                                                    |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)<br>_____                                                                                                                                                                                                                                                                                | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?<br>_____                                                                                                                                                   |                                                                               |                                                                                    |
| 22. I certify that (I) (this hospital) attended the deceased from <u>MIDNIGHT AUG 9 19 70</u> to <u>8:30 AM 8-9-19 70</u> that (I) (we) last saw the deceased alive on <u>AUG 9 19 70</u> and that (in (my) (our) opinion) death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                                                                                           |                                                                                                                                                                                       |                                                                               |                                                                                    |
| 23A. SIGNATURE<br><u>David Scheff MD</u>                                                                                                                                                                                                                                                                                                             |                                                                                                           | 23B. DATE SIGNED<br><u>8-9-70</u>                                                                                                                                                     |                                                                               | 23C. PHYSICIAN'S NAME (Type)<br><u>David Scheff, M.D.</u>                          |
| 23D. ADDRESS<br><u>The Johns Hopkins Hospital</u>                                                                                                                                                                                                                                                                                                    |                                                                                                           | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Cremation</u>                                                                                                                          |                                                                               |                                                                                    |
| 24B. DATE<br><u>8/10/70</u>                                                                                                                                                                                                                                                                                                                          | 24C. NAME of CEMETERY or CREMATORY<br><u>Johns Hopkins Hospital</u>                                       | 24D. LOCATION (City, town, or county) (State)<br><u>601 N Broadway Balto, Md.</u>                                                                                                     |                                                                               |                                                                                    |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>AUG 11 1970</u>                                                                                                                                                                                                                                                                                                |                                                                                                           | 25B. NAME OF REGISTRAR<br><u>Robert E. Farley, M.D.</u>                                                                                                                               |                                                                               | 25C. FUNERAL DIRECTOR ADDRESS<br><u>MORTUARY SERVICE - BCHD</u>                    |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

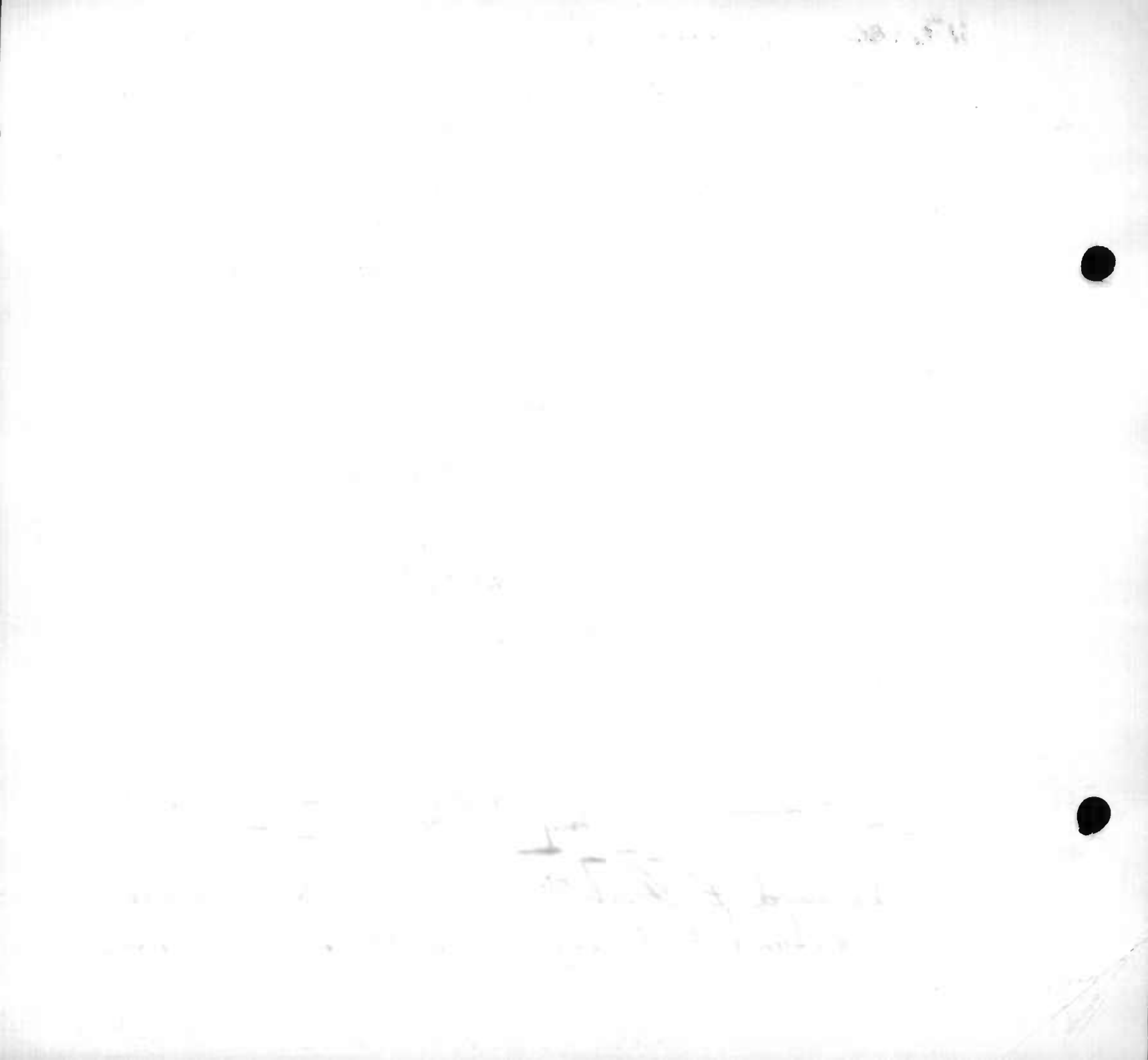
| Baltimore City Health Department                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             |                                     | REG. NO. 70 7977                                                                                         |                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span>C-500 70 7977</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                     |                                                                                                          |                                                     |
| 1. NAME OF DECEASED<br>(Type or Print) <b>JEAN COHEN</b>                                                                                                                                                                                                                                                                                            |                         | 2. DATE AND HOUR OF DEATH<br><b>08-08-70 12:04 A.M.</b>                                                                                                     |                                     |                                                                                                          |                                                     |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                              |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                                       |                                     |                                                                                                          |                                                     |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>THE JOHNS HOPKINS HOSPITAL<br/>BALTIMORE, MD 21205</b>                                                                                                                                                                                                                                                   |                         | A. STATE<br><b>MARYLAND</b>                                                                                                                                 |                                     | B. COUNTY<br><b>603</b>                                                                                  |                                                     |
|                                                                                                                                                                                                                                                                                                                                                     |                         | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                         |                                     | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                                     |
|                                                                                                                                                                                                                                                                                                                                                     |                         | E. STREET AND NUMBER<br><b>14 N. COLLINGTON AVE</b>                                                                                                         |                                     |                                                                                                          |                                                     |
| 5. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                             | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>08-27-27</b> | 9. AGE (In years last birthday)<br><b>42</b>                                                             | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Waitress</b>                                                                                                                                                                                                                                      |                         | 10B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>                                  |                                                     |
| 13. FATHER'S NAME<br><b>JOHN UNGER</b>                                                                                                                                                                                                                                                                                                              |                         | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth</b>                                                                                                                |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                               |                                                     |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                            |                         | 16. SOCIAL SECURITY NO.                                                                                                                                     |                                     | 17. INFORMANT<br><b>Mr. Bernard Cohen, 14 N. Collington Av., Balto., Md</b>                              |                                                     |
| 18. <b>E-911X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.)<br><b>Cardiac Arrest</b>                                                                                                        |                         | 19. CAUSE OF DEATH<br>IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Cardiac Arrest</b>                                                           |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                             |                                                     |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                      |                         | DUE TO, OR AS A CONSEQUENCE OF:<br><b>Foreign Body Aspiration</b>                                                                                           |                                     |                                                                                                          |                                                     |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                     |                                                                                                          |                                                     |
| 19A. DATE OF OPERATION<br><b>8-5-70</b>                                                                                                                                                                                                                                                                                                             |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                     | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                                                   |                                                     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>                                                                                                                                                                                                                           |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Home</b>                                                     |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>14 N. COLLINGTON AVE.</b> |                                                     |
| 21D. TIME OF INJURY (APPROX.)<br><b>8-5-70</b>                                                                                                                                                                                                                                                                                                      |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>                                        |                                     | 21F. HOW DID INJURY OCCUR?<br><b>APPARENTLY ASPIRATED PIECE OF MEAT</b>                                  |                                                     |
| 22. I certify that (I) (this hospital) attended the deceased from <b>8/5/70 12:00 PM</b> to <b>8/6/70 12:00 PM</b> and that (I) (we) last saw the deceased alive on <b>8/5/70 12:00 PM</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                     |                                                                                                          |                                                     |
| 23A. SIGNATURE<br><b>Knute S. Alfredson</b>                                                                                                                                                                                                                                                                                                         |                         | 23B. DATE SIGNED                                                                                                                                            |                                     | 23C. PHYSICIAN'S NAME (Type)<br><b>KNUTE S. ALFREDSON M.D.</b>                                           |                                                     |
| 23D. ADDRESS<br><b>THE JOHNS HOPKINS HOSPITAL</b>                                                                                                                                                                                                                                                                                                   |                         | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                   |                                     |                                                                                                          |                                                     |
| 24B. DATE<br><b>8/12/70</b>                                                                                                                                                                                                                                                                                                                         |                         | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Cemetery</b>                                                                                            |                                     | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                              |                                                     |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>AUG 11 1970</b>                                                                                                                                                                                                                                                                                               |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Jahnke, Jr.</b>                                                                                                      |                                     | 25C. FUNERAL DIRECTOR<br><b>Witzke, 4101 Edmondson Av., Balto., Md. 21229</b>                            |                                                     |



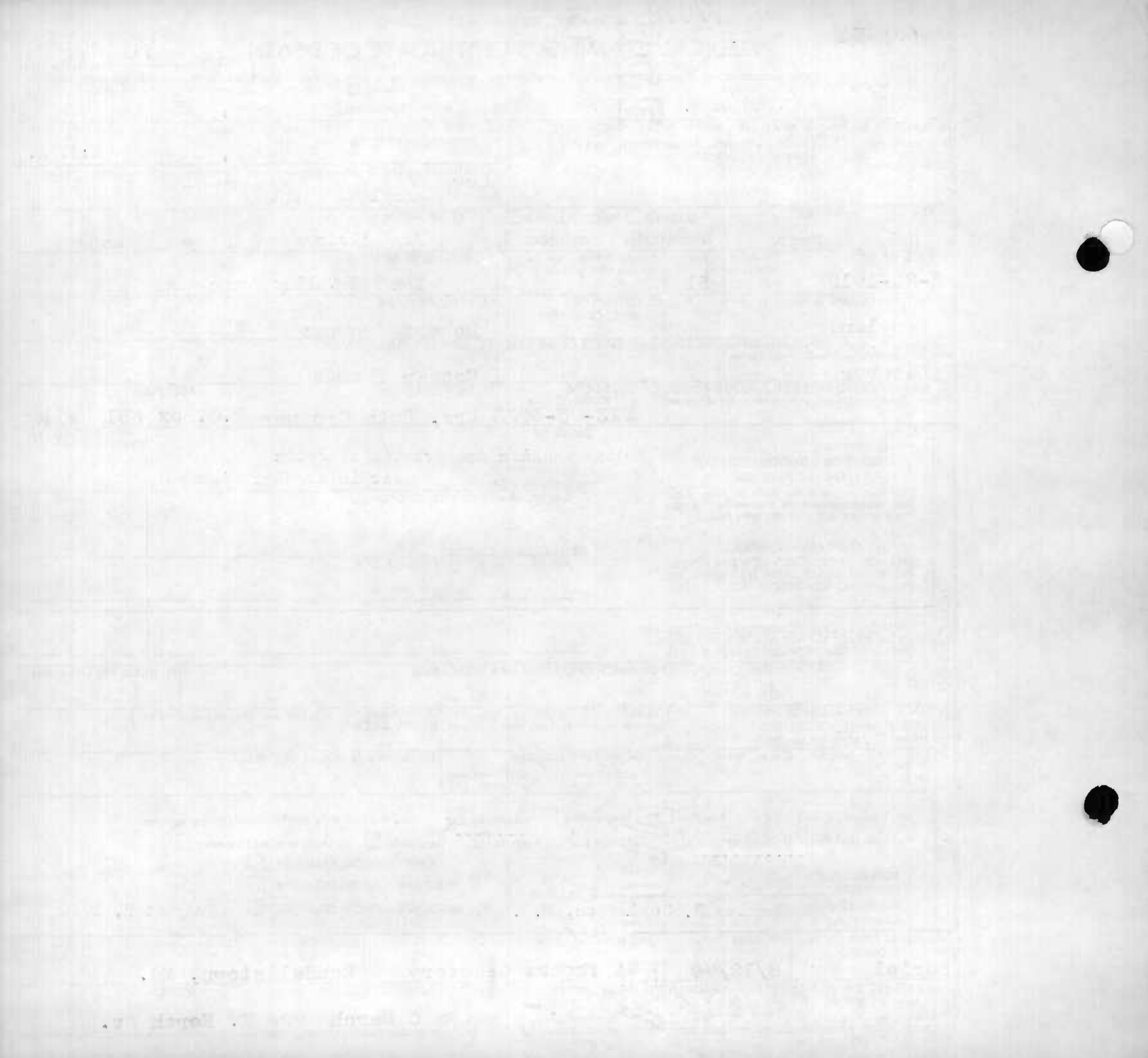
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <u>W-452</u> <u>70</u> <u>7978</u>                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                      |                                              | REG. NO. <u>70</u> <u>7978</u>                                                                                                  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Haywood Williams</u>                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                                                             |  | 2. DATE AND HOUR OF DEATH<br><u>6-Aug-70</u> <u>11:55</u> A.M.                                                                                                        |                                              |                                                                                                                                 |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                               |                     |                                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)<br>A. STATE <u>Md</u> B. COUNTY <u>BALT.</u>                                    |                                              |                                                                                                                                 |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>South Baltimore General Hospital</u>                                                                                                                                                                                                                                                                 |                     |                                                                                                                                                             |  | C. CITY OR TOWN<br><u>Baltimore</u>                                                                                                                                   |                                              | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                      |                     |                                                                                                                                                             |  | E. STREET AND NUMBER<br><u>2321 DRUID HILL AVE</u><br><u>1213 LIGHT ST.</u>                                                                                           |                                              |                                                                                                                                 |  |
| 5. SEX<br><u>M</u>                                                                                                                                                                                                                                                                                                                                                                                                   | 6. RACE<br><u>N</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>9/23/13</u>                                                                                                                                    | 9. AGE (In years last birthday)<br><u>56</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Mln.                                                                                |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>MOVING BUSINESS</u>                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                             |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>MOVING</u>                                                                                                                    |                                              | 11. BIRTHPLACE (State or foreign country)<br><u>Md.</u>                                                                         |  |
| 13. FATHER'S NAME<br><u>William Williams</u>                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br><u>Maggie Brown</u>                                                                                                                       |                                              |                                                                                                                                 |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>UNK</u>                                                                                                                                                                                                                                                                                               |                     |                                                                                                                                                             |  | 16. SOCIAL SECURITY NO.<br><u>215-03-1521</u><br><u>UNK</u>                                                                                                           |                                              | 17. INFORMANT<br><u>Roland Williams</u> ADDRESS<br><u>3522 Hilton Rd. Balt</u>                                                  |  |
| 18. <u>41241</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                   |                     |                                                                                                                                                             |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br><u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <u>CVA</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <u>ASCVD</u> |                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>4 days</u><br><u>1 month</u>                                                 |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><u>Previous CVA</u>                                                                                                                                                                                                                                                        |                     |                                                                                                                                                             |  |                                                                                                                                                                       |                                              |                                                                                                                                 |  |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                                                                                                   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 20A. AUTOPSY? (Yes or No)<br><u>No</u>                                                                                                                                |                                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                            |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nality medical examiner)                                                                                                                                                                                                                                                                                                       |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                              |                                              |                                                                                                                                 |  |
| 21D. TIME OF INJURY (Approx.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                         |                     | 21E. INJURY OCCURRED<br>White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                            |                                              |                                                                                                                                 |  |
| 22. I certify that <u>(this hospital)</u> attended the deceased from <u>9-July</u> 19 <u>70</u> to <u>6-Aug</u> 19 <u>70</u> that <u>(I)</u> <u>(we)</u> last saw the deceased alive on <u>6-Aug</u> 19 <u>70</u> and that <u>(in my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death. |                     |                                                                                                                                                             |  |                                                                                                                                                                       |                                              |                                                                                                                                 |  |
| 23A. SIGNATURE<br><u>Richard E Fisher</u> MD                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                                                                                             |  | 23B. DATE SIGNED<br><u>6-Aug-70</u>                                                                                                                                   |                                              | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Richard E Fisher</u> MD                                                                                                                                                                                                                                                                                                                                                           |                     |                                                                                                                                                             |  | 23D. ADDRESS<br><u>So. Balt. Gen. Hosp.</u>                                                                                                                           |                                              |                                                                                                                                 |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                            |                     | 24B. DATE<br><u>8/12</u>                                                                                                                                    |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>mt Ararat</u>                                                                                                                |                                              | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore</u>                                                               |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>AUG 11 1970</u>                                                                                                                                                                                                                                                                                                                                                                |                     | 25B. NAME OF REGISTRAR<br><u>Robert E. Fisher</u> MD                                                                                                        |  | 25C. FUNERAL DIRECTOR<br><u>W C Mpsm</u>                                                                                                                              |                                              | ADDRESS<br><u>938 E. North Ave</u>                                                                                              |  |



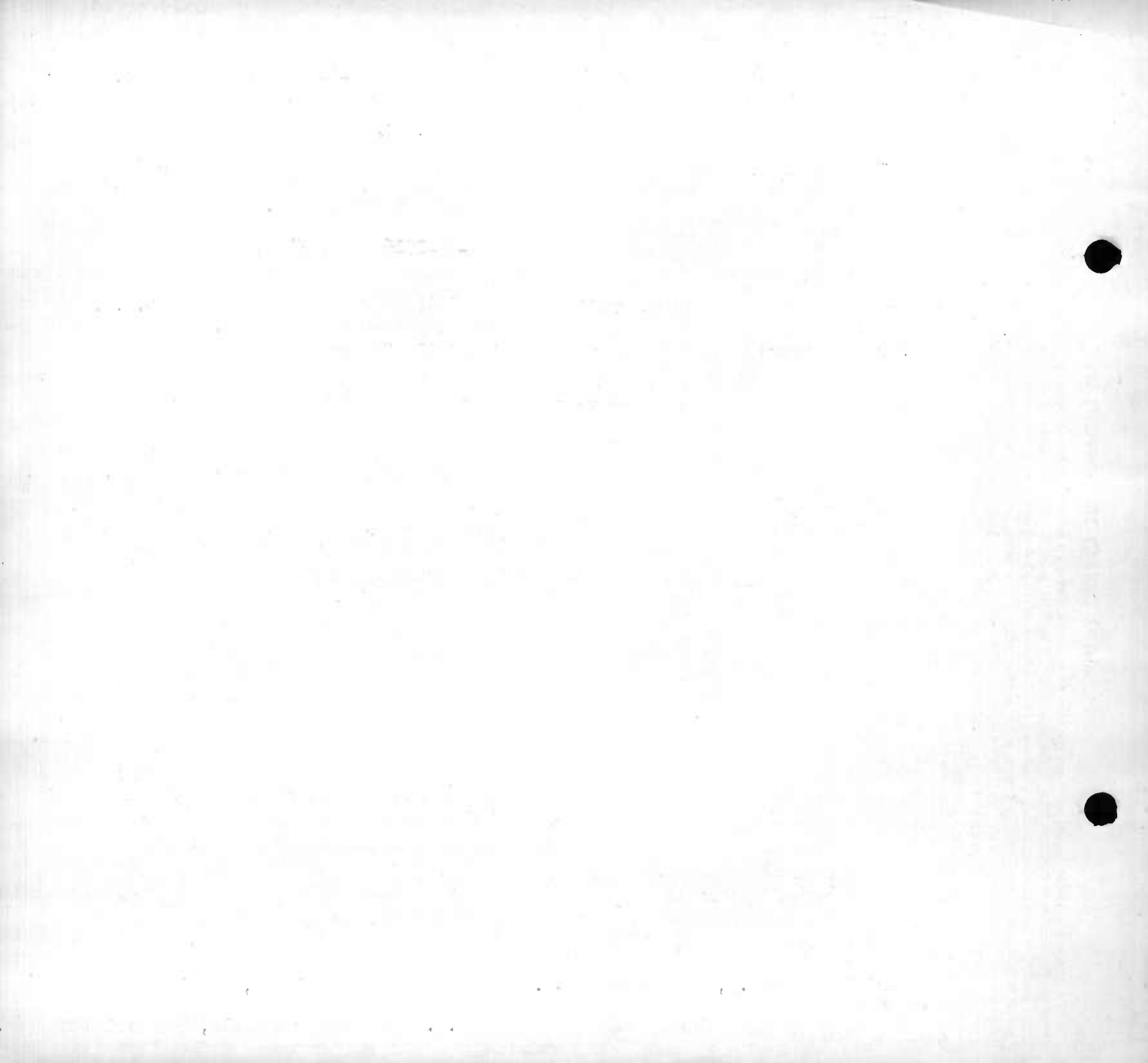
| 1. NAME OF DECEASED<br>(Type or Print)                                  |         | 2. DATE OF DEATH                                                                                                                                 |  | 3. DATE PRONOUNCED DEAD                                  |  | 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>(FULL NAME OF HOSPITAL OR INSTITUTION)        |  | 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |  |
|-------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|
| CLARENCE M. CROWNER                                                     |         | Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour<br>August 9, 1970 M.                            |  | Month Day Year Hour<br>August 9, 1970 1:57 A.M.          |  | 5 North Gorman Avenue                                                                                   |  | A. STATE Maryland B. COUNTY Baltimore 5300                                            |  |
| 6. SEX                                                                  | 7. RACE | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | C. CITY OR TOWN                                          |  | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                         |  |                                                                                       |  |
| Male                                                                    | Negro   |                                                                                                                                                  |  | Randallstown                                             |  |                                                                                                         |  |                                                                                       |  |
| 9. DATE OF BIRTH                                                        |         | 10. AGE (In years lost birthday)                                                                                                                 |  | 11. BIRTHPLACE (State or foreign country)                |  | 12. CITIZEN OF WHAT COUNTRY?                                                                            |  |                                                                                       |  |
| 3-20-1919                                                               |         | 51                                                                                                                                               |  | Maryland                                                 |  |                                                                                                         |  |                                                                                       |  |
| 13. FATHER'S NAME                                                       |         | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                       |  | 15. MOTHER'S MAIDEN NAME                                 |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) |  |                                                                                       |  |
| Robert Crowner                                                          |         | Laborer                                                                                                                                          |  | Esther Thomas                                            |  |                                                                                                         |  |                                                                                       |  |
| 17. SOCIAL SECURITY NO.                                                 |         | 18. INFORMANT                                                                                                                                    |  | 19. CAUSE OF DEATH                                       |  | 20. DATE OF OPERATION                                                                                   |  |                                                                                       |  |
| 213-05-0033                                                             |         | Mrs. Ruth Crowner                                                                                                                                |  | Hypertensive and arteriosclerotic cardiovascular disease |  | 21. AUTOPSY? (Yes or No)<br>Yes                                                                         |  |                                                                                       |  |
| 22. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |         | 23. HOW DID INJURY OCCUR?                                                                                                                        |  | 24. NAME OF CEMETERY or CREMATORY                        |  | 25. FUNERAL DIRECTOR                                                                                    |  |                                                                                       |  |
| 22. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |         | 23. HOW DID INJURY OCCUR?                                                                                                                        |  | St Thomas Cemetery                                       |  | Wm C March 928 E. North Av.                                                                             |  |                                                                                       |  |
| 24. LOCATION (City, town, or county) (State)                            |         | 25. NAME OF REGISTRAR                                                                                                                            |  | 26. DATE REC'D BY HEALTH DEPT.                           |  | 27. DATE SIGNED                                                                                         |  |                                                                                       |  |
| Randallstown, Md.                                                       |         | Robert E. Taylor, M.D.                                                                                                                           |  | AUG 11 1970                                              |  | August 9, 1970                                                                                          |  |                                                                                       |  |
| 28. BURIAL CREMATION, REMOVAL (Specify)                                 |         | 29. DATE                                                                                                                                         |  | 30. NAME OF CEMETERY or CREMATORY                        |  | 31. DATE SIGNED                                                                                         |  |                                                                                       |  |
| Burial                                                                  |         | 8/12/70                                                                                                                                          |  | St Thomas Cemetery                                       |  | August 9, 1970                                                                                          |  |                                                                                       |  |



# FUNERAL DIRECTOR: IMPORTANT

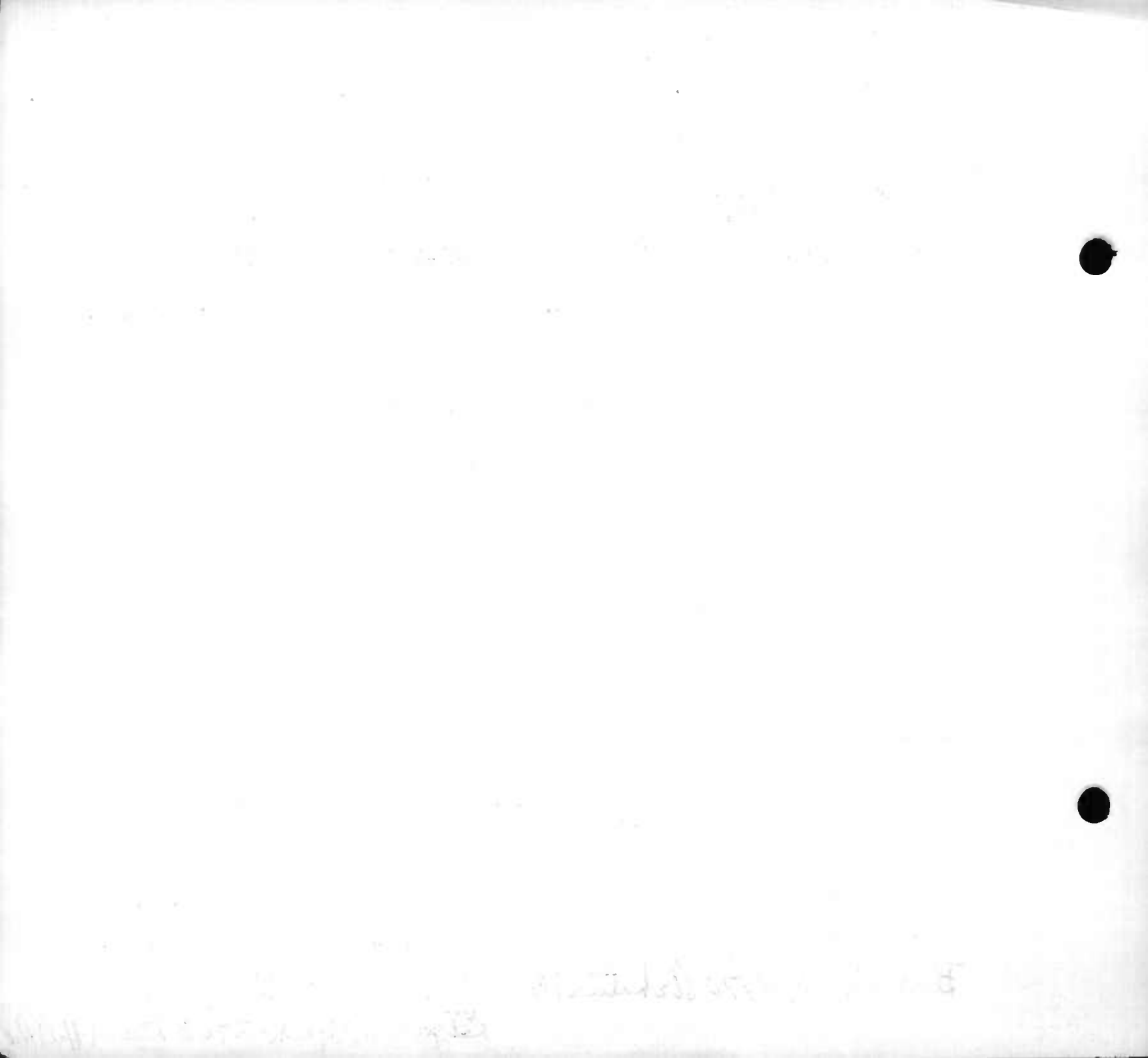
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                  |  |                                                                                                                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 4-638 70 7980                                                                                                                                                                                                                                                                                                                                     |  | BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                 |  | REG. NO. 70 7980                                                                                                                                            |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                         |  | 1. NAME OF DECEASED<br>(Type or Print) JOHN HOWARD (Roland)                                                                                                                                                      |  | 2. DATE AND HOUR OF DEATH<br>8-3-70 7:50 P M.                                                                                                               |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>BOLTON HILL NURSING CENTER                                                                                                                                             |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE MARYLAND<br>B. COUNTY 2841                                                                                     |  | C. CITY OR TOWN BALTIMORE<br>D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 5. SEX<br>M                                                                                                                                                                                                                                                                                                                                       |  | 6. RACE<br>N                                                                                                                                                                                                     |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer                                                                                                                                                                                                                                            |  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Construction                                                                                                                                                                |  | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND                                                                                                       |  |
| 13. FATHER'S NAME<br>Clarence Howard                                                                                                                                                                                                                                                                                                              |  | 14. MOTHER'S MAIDEN NAME<br>Estelle Howard Brown                                                                                                                                                                 |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No                                                                                                                                                                                                                                    |  | 16. SOCIAL SECURITY NO.<br>220-03-2376                                                                                                                                                                           |  | 17. INFORMANT<br>ADMISSION RECORD                                                                                                                           |  |
| 18. 342.1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF: <i>Parkinson's disease</i><br>(B) <i>arteriosclerosis generalized</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <i>old C.V.A. right</i> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>years</i><br><i>years</i>                                                                                |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                            |  |                                                                                                                                                                                                                  |  |                                                                                                                                                             |  |
| 19A. DATE OF OPERATION<br>0                                                                                                                                                                                                                                                                                                                       |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                 |  | 20A. AUTOPSY? (Yes or No)                                                                                                                                   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                           |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                                         |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                                                    |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)                                                                                                                                                                                                                                                                                         |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                                        |  | 21F. HOW DID INJURY OCCUR?                                                                                                                                  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 10/21 1968 to 8/3 1970, that (I) (we) last saw the deceased alive on 8/4 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                          |  |                                                                                                                                                                                                                  |  |                                                                                                                                                             |  |
| 23A. SIGNATURE<br><i>Alan H. MacIntyre</i>                                                                                                                                                                                                                                                                                                        |  | 23B. DATE SIGNED<br>8/4/70                                                                                                                                                                                       |  | 23C. PHYSICIAN'S NAME (Type)<br>ALLAN H. MACINTYRE MD                                                                                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                |  | 24B. DATE<br>Aug. 5, 70                                                                                                                                                                                          |  | 24C. NAME OF CEMETERY or CREMATORY<br>Arbutus Mem. Park                                                                                                     |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>AUG 11 1970                                                                                                                                                                                                                                                                                                    |  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor                                                                                                                                                                       |  | 25C. FUNERAL DIRECTOR<br>K.H. Law Funeral Chapels, 4609 Park HGTs Ave.                                                                                      |  |
| 24D. LOCATION (City, town, or county)<br>Baltimore, Maryland                                                                                                                                                                                                                                                                                      |  | 24E. ADDRESS<br>2 E Red ST Baltimore 21202                                                                                                                                                                       |  | 24F. ADDRESS<br>K.H. Law Funeral Chapels, 4609 Park HGTs Ave.                                                                                               |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                        | REG. NO. 70 7981                                                             |                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------------|
| J-525 70 7981                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                        | CERTIFICATE OF DEATH                                                         |                                                                  |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Johnson, James A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>8-7-70 13:30 A.M.</b>                                                                                                                                                                                                                                                                                  |                                                                              |                                                                  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>39 Provident Hospital<br/>1514 Divison Street<br/>Baltimore, Maryland 21217</b>                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>1303</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>2450 Druid Hill Ave. 21217</b> |                                                                              |                                                                  |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 6. RACE<br><b>Negro</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-24-1893</b>                                                                                                                                                                                                                                                                                                  | 9. AGE (In years lost birthday) <b>76</b>                                    | If Under 1 Yr. Months: Days: Hours: Min.                         |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired-Engineer</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Steamship Co.</b>                                                                                                   |                                                                                                                                                                                                                                                                                                                                        | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia, Cumberland Co.</b> |                                                                  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             | 13. FATHER'S NAME<br><b>Richard Johnson</b>                                                                                                                                                                                                                                                                                            |                                                                              |                                                                  |
| 14. MOTHER'S MAIDEN NAME<br><b>Emiley ----</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                  |                                                                              |                                                                  |
| 16. SOCIAL SECURITY NO.<br><b>217-14-1370</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             | 17. INFORMANT<br><b>Mrs. Josephine Johnson-Wife</b>                                                                                                                                                                                                                                                                                    |                                                                              |                                                                  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Pulmonary Edema</b> |                         |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Cerebrovascular Accident 2 day</b><br><b>Generalized Arteriosclerosis - yrs</b><br><b>Pul. Edema 2' B</b><br><b>1 day</b>                                                                                                                                                           |                                                                              |                                                                  |
| 19A. DATE OF OPERATION<br><b>8-5-70</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                                                        | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>                                      |                                                                  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                                                        | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)     |                                                                  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                                                                                                                                                                        | 21F. HOW DID INJURY OCCUR?                                                   |                                                                  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>8-5-70</b> 19 to <b>8-7-70</b> 19 that (I) (we) last saw the deceased alive on <b>8-7-70</b> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                        |                                                                              |                                                                  |
| 23A. SIGNATURE<br><b>Ruperto Manankil</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             | 23B. DATE SIGNED<br><b>Aug. 7, 1970</b>                                                                                                                                                                                                                                                                                                |                                                                              | 23C. PHYSICIAN'S NAME (Type)<br><b>RUPERTO MANANKIL</b>          |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             | 24B. DATE<br><b>8/10/70</b>                                                                                                                                                                                                                                                                                                            |                                                                              | 24C. NAME OF CEMETERY OR CREMATORIUM<br><b>Arbutus Mem. Park</b> |
| 24D. LOCATION (City, town, or county) (State)<br><b>Arbutus, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             | 25A. DATE REC'D BY HEALTH DEPT.<br><b>AUG 11 1970</b>                                                                                                                                                                                                                                                                                  |                                                                              |                                                                  |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Farber, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             | 25C. FUNERAL DIRECTOR<br><b>Edgar L. Lynch - 2463 Druid Hill Ave.</b>                                                                                                                                                                                                                                                                  |                                                                              |                                                                  |



S-530

70 7982

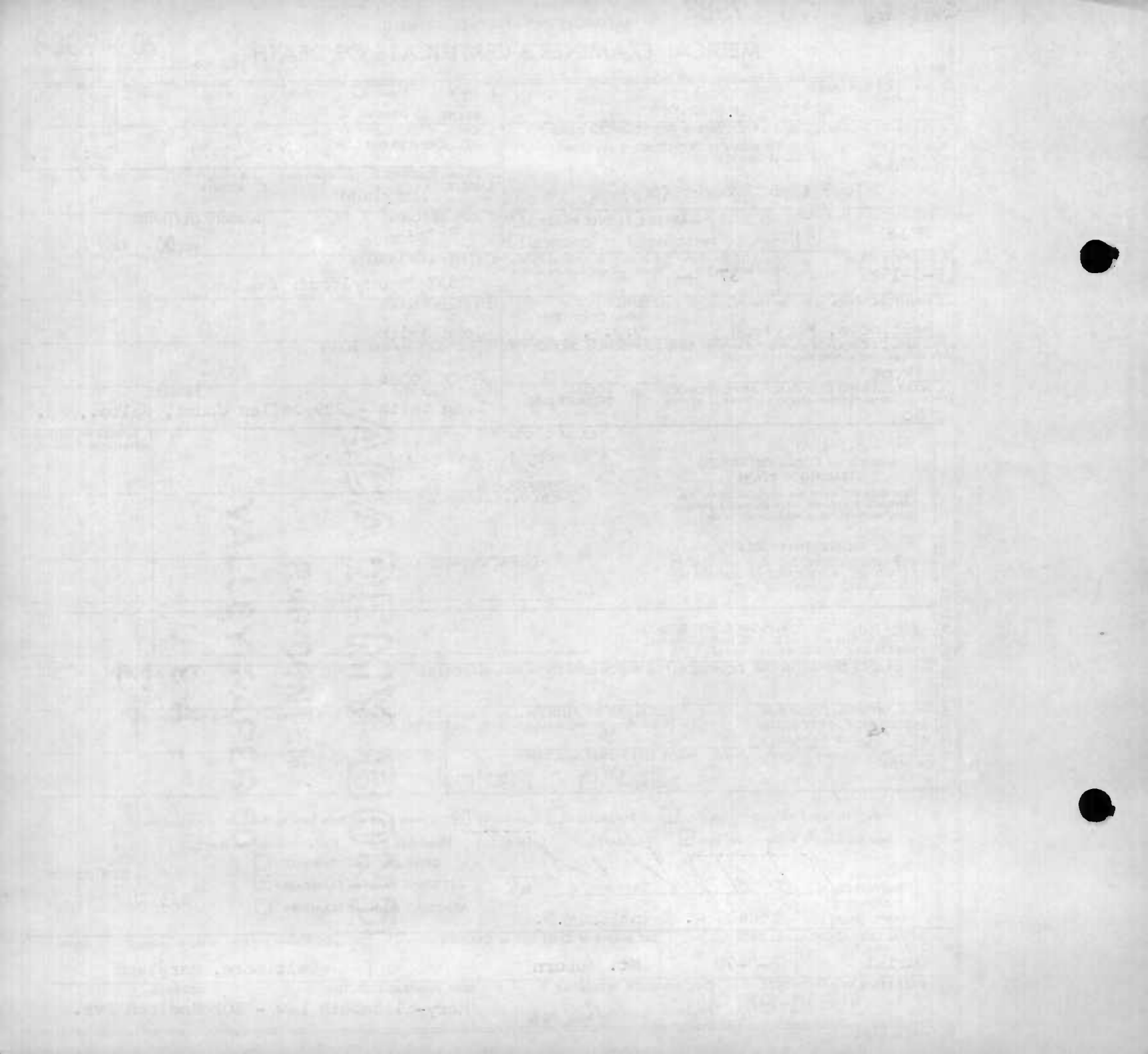
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 7982

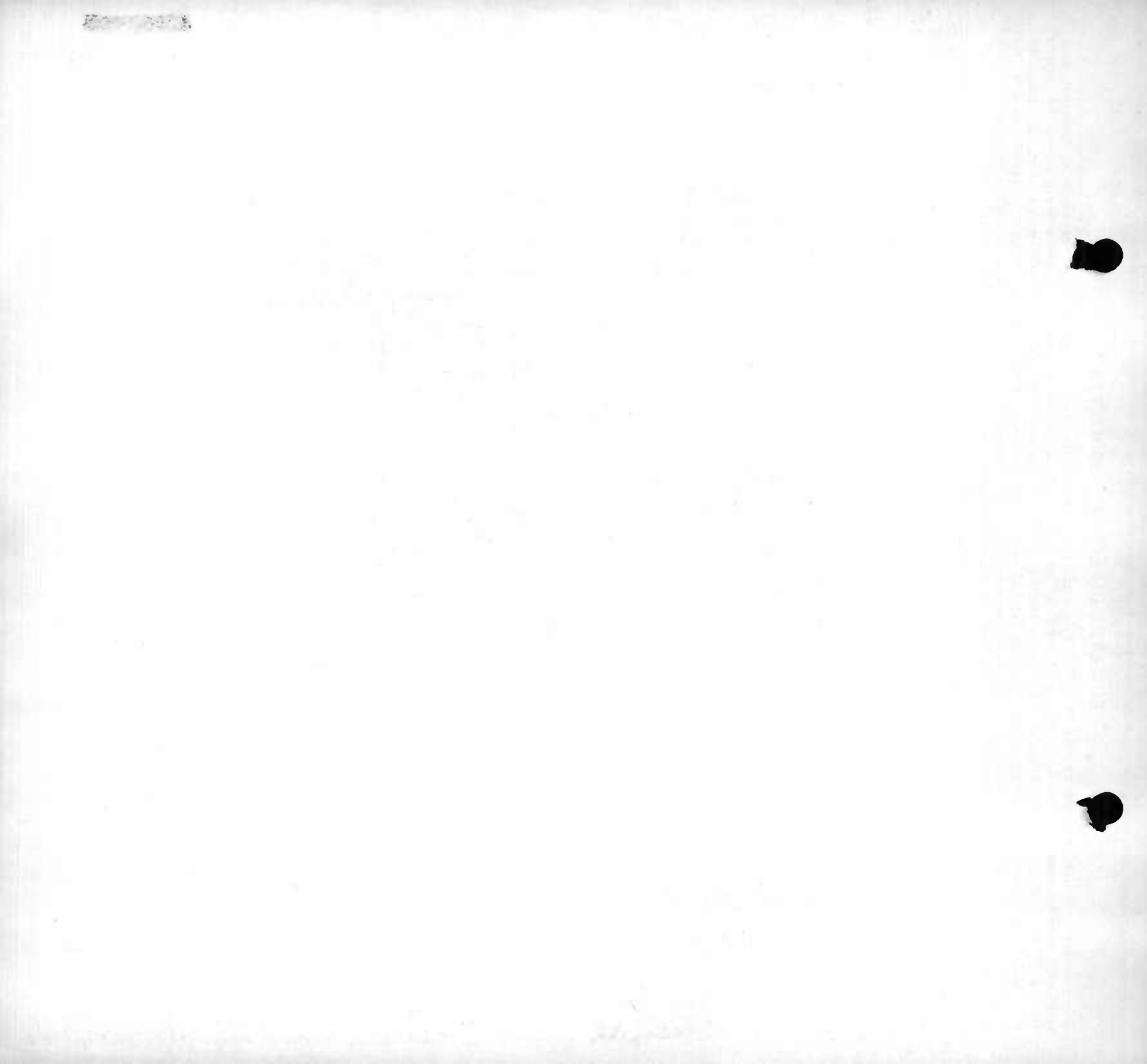
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |  |                                                                                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 1. NAME OF DECEASED<br>(Type or Print)<br><b>ALFRED P. SMITH</b>                                                                                            |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.                         |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>1403 Brunt Street (DOA)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>August 4, 1970 12:30 P.</b>                                                                            |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>1403</b> |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 7. RACE<br><b>Negro</b> | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | C. CITY OR TOWN<br><b>Baltimore</b>                                                                                                     |  |
| 9. DATE OF BIRTH<br><b>9-3-1932</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 10. AGE (In years lost birthday) <b>34</b><br>If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.                                                        |  | E. STREET AND NUMBER<br><b>1852 Pennsylvania Avenue</b>                                                                                 |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                               |  | 13. FATHER'S NAME<br><b>John Smith</b>                                                                                                  |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME<br><b>Mary Johns</b>                                                                                           |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 17. SOCIAL SECURITY NO.                                                                                                                                     |  | 18. INFORMANT<br><b>Leon Smith - 289 Dallas Court, Balto., Md.</b>                                                                      |  |
| 19. <b>571.81</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Fatty Metamorphosis of Liver</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         | CAUSE OF DEATH                                                                                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                            |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                      |  |                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                         |  |                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                         |  |                                                                                                                                         |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |  |                                                                                                                                         |  |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  | 21. AUTOPSY? (Yes or No)<br><b>yes</b>                                                                                                  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?                                                                |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                   |  | 22F. HOW DID INJURY OCCUR?                                                                                                              |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D.<br>EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <b>8/5/70</b> |                         |                                                                                                                                                             |  |                                                                                                                                         |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 24B. DATE<br><b>8-8-70</b>                                                                                                                                  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Mt. Auburn</b>                                                                                 |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>AUG 11 1970</b>                                                                                                       |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Farber, M.D.</b>                                                                                 |  |
| 25C. FUNERAL DIRECTOR<br><b>Mary-Elizabeth Law - 802 Madison Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                         | 25D. ADDRESS                                                                                                                                                |  |                                                                                                                                         |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department                                                                                                                                                                                                                                                                                     |           |                                                                                                                                                                                          |                                                               | Registered No.                                                                                              |                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 70 7983                                                                                                                                                                                                                                                                                                    |           | CERTIFICATE OF DEATH                                                                                                                                                                     |                                                               | 70 7983                                                                                                     |                                                           |
| M.E. CASE NO.                                                                                                                                                                                                                                                                                                        |           | 1. NAME OF DECEASED (Type or Print) <del>KASZUBSKI</del> KASZUBSKI, Mr. FRANK                                                                                                            |                                                               | 2. DATE AND HOUR OF DEATH 8/6/70 12 23 PM                                                                   |                                                           |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND                                                                                                                                                                                                                                                                             |           | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)                                                                                                    |                                                               |                                                                                                             |                                                           |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>Maryland General Hospital<br>YOMCH                                                                                                                                                                      |           | A. STATE Md. B. COUNTY Balt<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore<br>D. STREET ADDRESS (If rural, give location)<br>706 S. Ellwood Ave |                                                               |                                                                                                             |                                                           |
| 5. SEX m                                                                                                                                                                                                                                                                                                             | 6. RACE w | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married                                                                                                                           | 8. DATE OF BIRTH 03-24-02                                     | 9. AGE (In years last birthday) 68                                                                          | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired                                                                                                                                                                                                                  |           | 10B. KIND OF BUSINESS OR INDUSTRY xx                                                                                                                                                     | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland |                                                                                                             | 12. CITIZEN OF WHAT COUNTRY? U.S.A.                       |
| 13. FATHER'S NAME Marlon Kaszubski                                                                                                                                                                                                                                                                                   |           | 14. MOTHER'S MAIDEN NAME Josephine - unknown                                                                                                                                             |                                                               | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No |                                                           |
| 16. SOCIAL SECURITY NO. 705-09-6515                                                                                                                                                                                                                                                                                  |           | 17. INFORMANT Wife                                                                                                                                                                       |                                                               | ADDRESS same                                                                                                |                                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)                                                                                                                      |           | CAUSE OF DEATH (A) DUE TO Congestive Heart failure                                                                                                                                       |                                                               | INTERVAL BETWEEN ONSET AND DEATH                                                                            |                                                           |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)                                                                                                                                                                                        |           | (B) DUE TO Arrhythmia + MI                                                                                                                                                               |                                                               |                                                                                                             |                                                           |
|                                                                                                                                                                                                                                                                                                                      |           | (C) Pulm Emboli, Isch. Cordio myopathy                                                                                                                                                   |                                                               |                                                                                                             |                                                           |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                                                                                                                                                                                    |           |                                                                                                                                                                                          |                                                               |                                                                                                             |                                                           |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                               |           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                         |                                                               | 20A. AUTOPSY? (Yes or No) none                                                                              |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)                                                                                                                                                                                                                                |           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                                                 |                                                               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                    |                                                           |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                            |           | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                                                   |                                                               | 21F. HOW DID INJURY OCCUR?                                                                                  |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from 07-06-70 19 70 to 08-06- 19 70, that (I) (we) lost saw the deceased alive on 08-06- 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |           |                                                                                                                                                                                          |                                                               |                                                                                                             |                                                           |
| 23A. SIGNATURE [Signature]                                                                                                                                                                                                                                                                                           |           | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                                                     |                                                               | 23B. DATE SIGNED 8/6/70                                                                                     |                                                           |
| 23C. PHYSICIAN'S NAME (Type) B.G. MATTHEWS                                                                                                                                                                                                                                                                           |           | M.D. 23D. ADDRESS MCH                                                                                                                                                                    |                                                               |                                                                                                             |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                      |           | 24B. DATE 8-10-70                                                                                                                                                                        |                                                               | 24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery                                                     |                                                           |
|                                                                                                                                                                                                                                                                                                                      |           |                                                                                                                                                                                          |                                                               | 24D. LOCATION (City, town, or county) (State) Baltimore, Md.                                                |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 11 1970                                                                                                                                                                                                                                                                          |           | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D.                                                                                                                                            |                                                               | 25C. FUNERAL DIRECTOR Nicholas J. Matthews ADDRESS 3021 Eastern Ave., Baltimore, Md.                        |                                                           |

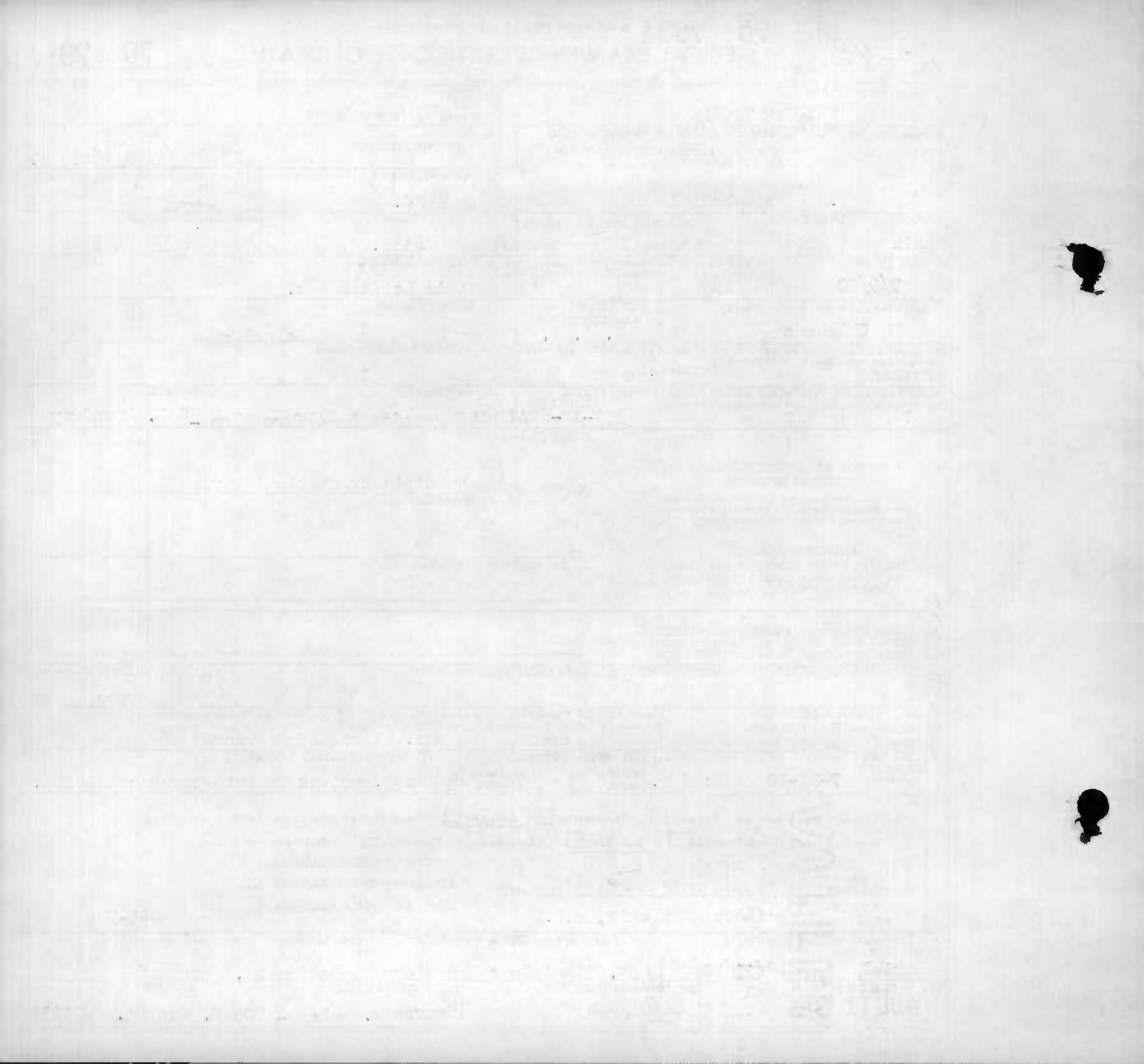


8-543

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 7984

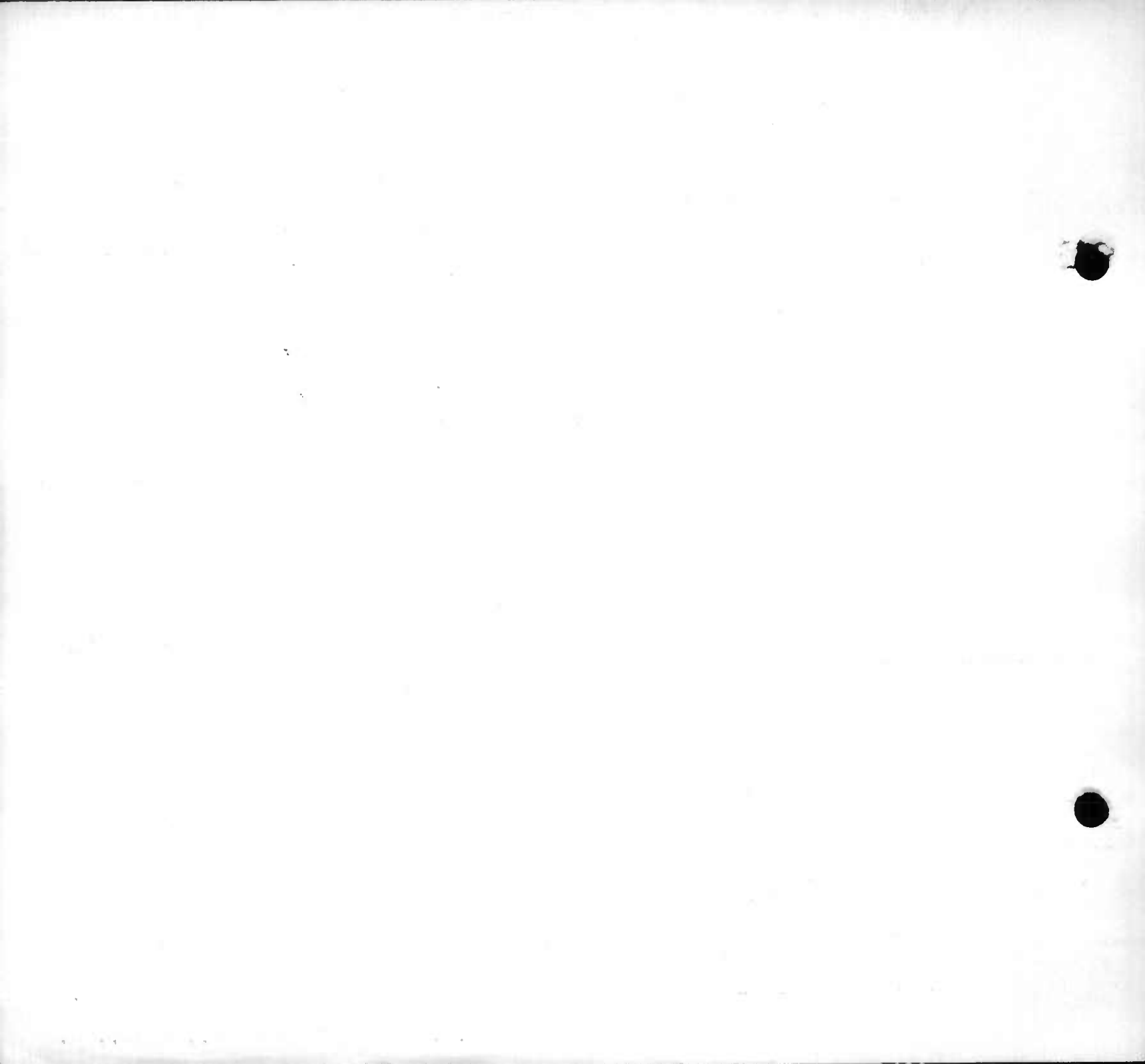
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>LEROY REYNOLDS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> M.                                                                                          |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>40 St. Agnes Hospital</b>                                                                                                                                                                                                                                                                                                                                     |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>7 31 1970 4:10 P.M.</b>                                                                                                                             |  |
| 6. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 7. RACE<br><b>White</b>                                                                                                                                                                                  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                         |  | C. CITY OR TOWN<br><b>Balto.</b>                                                                                                                                                                         |  |
| 9. DATE OF BIRTH<br><b>9/9/20</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10. AGE (In years last birthday)<br><b>49</b>                                                                                                                                                            |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Oklahoma</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                                                                                          |  |
| 13. FATHER'S NAME<br><b>? Reynolds</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>2582</b>                                                                      |  |
| 15. MOTHER'S MAIDEN NAME<br><b>?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>? ?</b>                                                                                 |  |
| 17. SOCIAL SECURITY NO.<br><b>557-18-6241</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 18. INFORMANT ADDRESS<br><b>MMU Pension &amp; Welfare Plan - 8 N. Broadway</b>                                                                                                                           |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>E812.10</b><br><b>Multiple traumatic injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(A) IMMEDIATE CAUSE<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                             |  |
| 20A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                         |  |
| 21. AUTOPSY? (Yes or No)<br><b>yes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                          |  |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>Rt. #1 and Pine Avenue</b>                                                                                                |  |
| 22D. TIME (Month) (Day) (Year) (Hour) (Approx.)<br><b>8-31-70 4:05 P.M.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                        |  |
| 22F. HOW DID INJURY OCCUR?<br><b>Subj. driver in auto-truck collision.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 23.                                                                                                                                                                                                      |  |
| I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                                                                                                  |  |                                                                                                                                                                                                          |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br><b>Isidore Mihalakis, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br><b>8-1-70</b> |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 24B. DATE<br><b>8/11/70</b>                                                                                                                                                                              |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>St. Stanislaus Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                                                                                                                              |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>AUG 11 1970</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Farley, M.D.</b>                                                                                                                                                  |  |
| 25C. FUNERAL DIRECTOR ADDRESS<br><b>George A. Weber - 705 S. Ann St. #21231</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                          |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

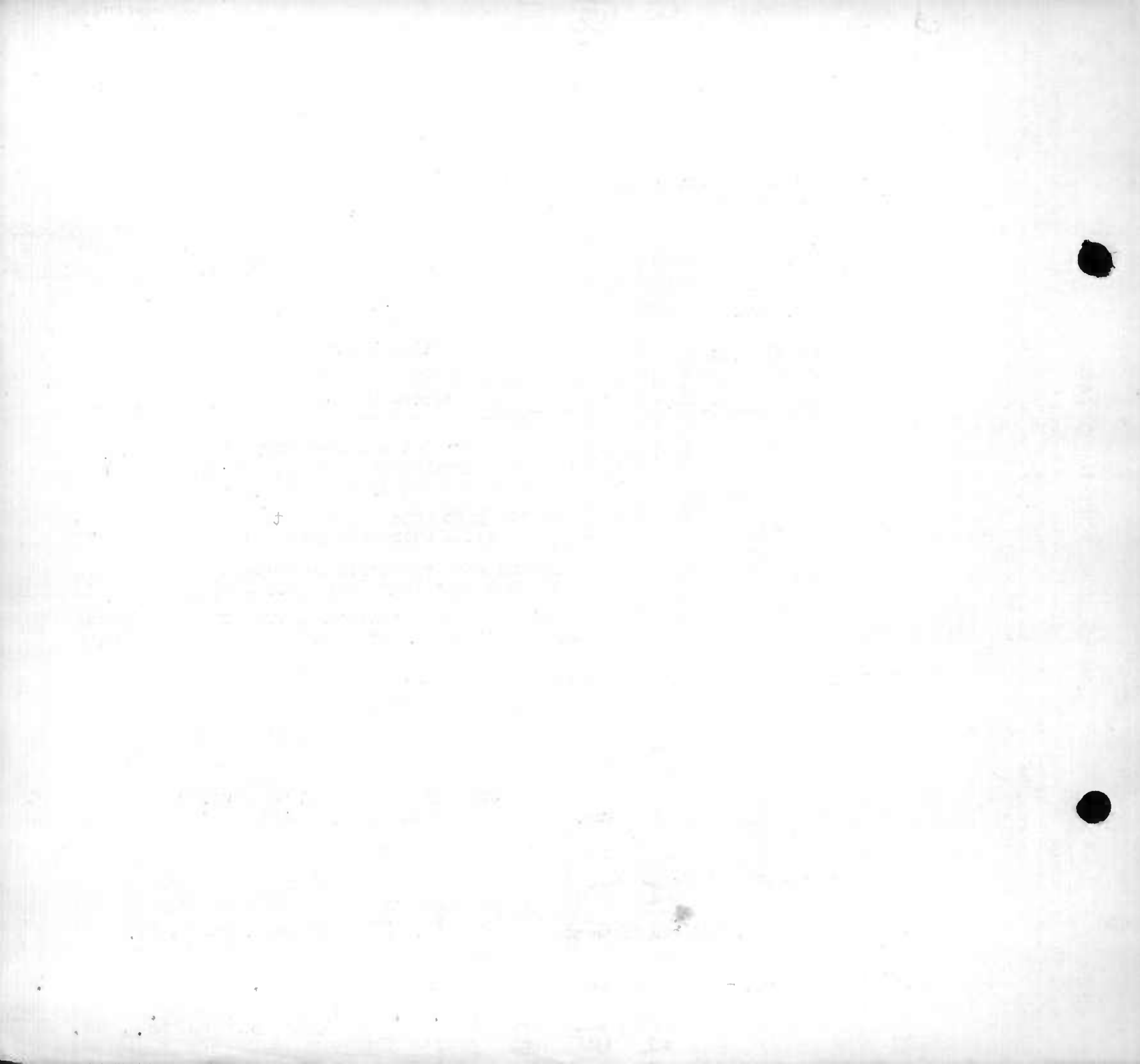
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                    |                     |                                                                                                                                                  |                                                     | 70 7985                                                                                                                                                                                                            |                                                                | 70 7985                                                                                       |                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------|
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                           |                     |                                                                                                                                                  |                                                     | 70 7985                                                                                                                                                                                                            |                                                                | REG. NO.                                                                                      |                                            |
| 1. NAME OF DECEASED<br>(Type or Print) <b>POLLY MARTIN</b>                                                                                                                                                                                                                                                                                          |                     |                                                                                                                                                  |                                                     | 2. DATE AND HOUR OF DEATH<br><b>8/9/70 1:45 P.M.</b>                                                                                                                                                               |                                                                |                                                                                               |                                            |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>MONTEBELLO STATE HOSPITAL</b>                                                                                                                                                                                                                                                          |                     |                                                                                                                                                  |                                                     | 4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>2740</b>                                                                                 |                                                                |                                                                                               |                                            |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>MONTEBELLO STATE HOSPITAL</b>                                                                                                                                                                                                       |                     |                                                                                                                                                  |                                                     | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                                                                                |                                                                | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                            |
|                                                                                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                                  |                                                     | E. STREET AND NUMBER<br><b>6114 Pimlico Road</b>                                                                                                                                                                   |                                                                |                                                                                               |                                            |
| 5. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                  | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8-18-13</b>                  | 9. AGE (In years last birthday)<br><b>56</b>                                                                                                                                                                       | If Under 1 Yr. Months Days                                     | If Under 24 Hrs. Hours Min.                                                                   |                                            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>REGISTERED NURSE</b>                                                                                                                                                                                                                              |                     |                                                                                                                                                  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>MEDICAL</b> |                                                                                                                                                                                                                    | 11. BIRTHPLACE (State or foreign country)<br><b>MO.</b>        |                                                                                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |
| 13. FATHER'S NAME<br><b>JOSEPH MARTIN</b>                                                                                                                                                                                                                                                                                                           |                     |                                                                                                                                                  |                                                     | 14. MOTHER'S MAIDEN NAME<br><b>ANNA JACOBS</b>                                                                                                                                                                     |                                                                |                                                                                               |                                            |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                               |                     |                                                                                                                                                  | 16. SOCIAL SECURITY NO.<br><b>216-16-6220</b>       |                                                                                                                                                                                                                    | 17. INFORMANT ADDRESS<br><b>MONTEBELLO STATE Hosp. Records</b> |                                                                                               |                                            |
| 18. CAUSE OF DEATH<br><b>03891</b>                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                                                  |                                                     | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Septicemia</b> |                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hrs.</b>                                |                                            |
|                                                                                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                                  |                                                     | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                |                                                                |                                                                                               |                                            |
|                                                                                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                                  |                                                     | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                |                                                                |                                                                                               |                                            |
|                                                                                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                                  |                                                     | (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                |                                                                |                                                                                               |                                            |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>Rheumatic Heart disease - Severe degenerative changes. Allergic myocarditis.</b>                                                                                                                       |                     |                                                                                                                                                  |                                                     |                                                                                                                                                                                                                    |                                                                |                                                                                               |                                            |
| 19A. DATE OF OPERATION<br><b>2</b>                                                                                                                                                                                                                                                                                                                  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                 |                                                     | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>                                                                                                                                                                            |                                                                | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>To be done</b>     |                                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                         |                                                     | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                                                                                                                        |                                                                |                                                                                               |                                            |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                        |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                        |                                                     | 21F. HOW DID INJURY OCCUR?                                                                                                                                                                                         |                                                                |                                                                                               |                                            |
| 22. I certify that (I) (this hospital) attended the deceased from <b>7-20</b> 19 <b>70</b> to <b>8-9</b> 19 <b>70</b> that (I) (we) last saw the deceased alive on <b>8-9</b> 19 <b>70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |                                                                                                                                                  |                                                     |                                                                                                                                                                                                                    |                                                                |                                                                                               |                                            |
| 23A. SIGNATURE<br><b>J. Fuxa</b>                                                                                                                                                                                                                                                                                                                    |                     |                                                                                                                                                  |                                                     | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                                                                                    |                                                                | 23B. DATE SIGNED<br><b>8-9-70</b>                                                             |                                            |
| 23C. PHYSICIAN'S NAME (Type)<br><b>JORGE G. FUXA</b>                                                                                                                                                                                                                                                                                                |                     |                                                                                                                                                  |                                                     | 23D. ADDRESS<br><b>M.D. 2201 ARGONNE DR. BALTIMORE Md.</b>                                                                                                                                                         |                                                                |                                                                                               |                                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                           |                     | 24B. DATE<br><b>8-13-70</b>                                                                                                                      |                                                     | 24C. NAME OF CEMETERY or CREMATORY<br><b>Holy Redeemer</b>                                                                                                                                                         |                                                                | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md.</b>                         |                                            |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>AUG 11 1970</b>                                                                                                                                                                                                                                                                                               |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>                                                                                          |                                                     | 25C. FUNERAL DIRECTOR ADDRESS<br><b>H.W. Jenkins &amp; Sons Co., Balto., Md.</b>                                                                                                                                   |                                                                |                                                                                               |                                            |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

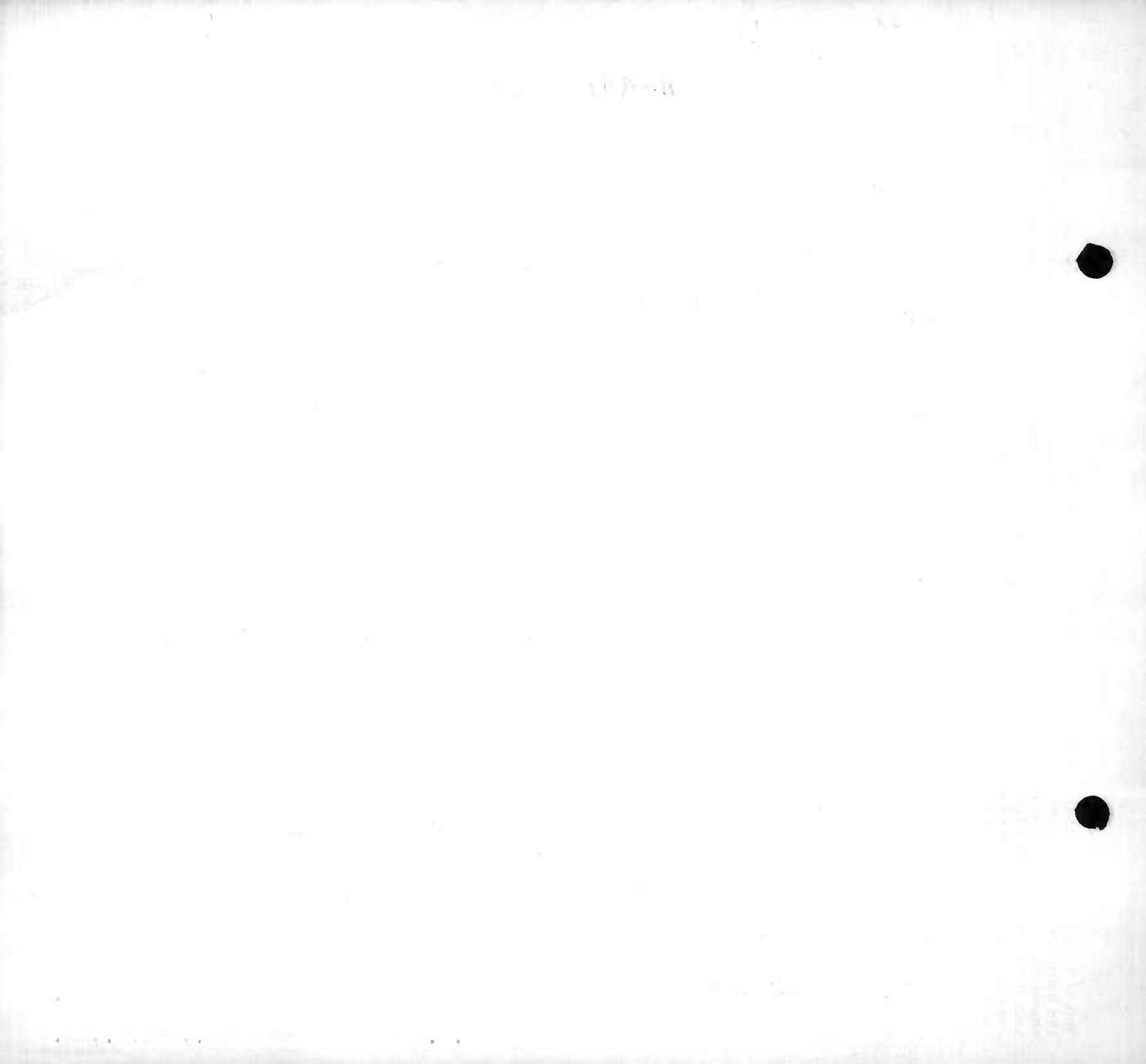
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                                             |                                                                                                                                      | REG. NO. 70 7986                                                                                                                                                                                                                                                                                                        |                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Thomas Gabriel Mc Nicholas</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                                             |                                                                                                                                      | 2. DATE AND HOUR OF DEATH<br><b>Aug. 9, 1970 8:20 P M.</b>                                                                                                                                                                                                                                                              |                                                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>US Public Health Service Hospital<br/>2100 Wyman Parkway</b>                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                             |                                                                                                                                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY <b>1206</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>5 E. 27th Street</b> |                                                           |
| 5. SEX <b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 6. RACE <b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1/7/86</b>                                                                                                    | 9. AGE (In years last birthday) <b>84</b>                                                                                                                                                                                                                                                                               | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired LT. Col.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                  |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>USA</b>                                                                                      |                                                                                                                                                                                                                                                                                                                         | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                             | 13. FATHER'S NAME<br><b>Thomas Mc Nicholas</b>                                                                                       |                                                                                                                                                                                                                                                                                                                         |                                                           |
| 14. MOTHER'S MAIDEN NAME<br><b>Ellen Mannion</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                                             | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes USA 1904-1937</b> |                                                                                                                                                                                                                                                                                                                         |                                                           |
| 16. SOCIAL SECURITY NO.<br><b>161-12-0835</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                                             | 17. INFORMANT ADDRESS<br><b>Records- US PHS Hospital, Balto, Md.</b>                                                                 |                                                                                                                                                                                                                                                                                                                         |                                                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Peritonitis secondary to breakdown of colon, rectum anastomosis site</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Status post anterior resection of rectal adenocarcinoma</b><br><b>Status post resection of segment of colon &amp; colostomy (2nd operation)</b> |                  |                                                                                                                                                             |                                                                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 days ?</b><br><b>9 days</b><br><b>2 days</b>                                                                                                                                                                                                                       |                                                           |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>Generalized arteriosclerosis, severe Benign prostatic hypertrophy</b>                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                                             |                                                                                                                                      | Years<br>Years                                                                                                                                                                                                                                                                                                          |                                                           |
| 19A. DATE OF OPERATION<br><b>7-30-70 &amp; 8-7-70</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma of rectum</b>                                                                              |                                                                                                                                      | 20A. AUTOPSY? (Yes or No)<br><b>yes</b>                                                                                                                                                                                                                                                                                 |                                                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><input type="checkbox"/>                                        |                                                                                                                                      | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)<br><input type="checkbox"/>                                                                                                                                                                                                                 |                                                           |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                      | 21F. HOW DID INJURY OCCUR?<br><input type="checkbox"/>                                                                                                                                                                                                                                                                  |                                                           |
| 22. I certify that (I) (this hospital) attended the deceased from <b>July 13 19 70</b> to <b>Aug. 9 19 70</b> , that (I) (we) last saw the deceased alive on <b>Aug. 9 19 70</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                 |                  |                                                                                                                                                             |                                                                                                                                      |                                                                                                                                                                                                                                                                                                                         |                                                           |
| 23A. SIGNATURE<br><b>James M Weaver</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                                             |                                                                                                                                      | 23B. DATE SIGNED<br><b>8/10/70</b>                                                                                                                                                                                                                                                                                      |                                                           |
| 23C. PHYSICIAN'S NAME (Type)<br><b>James M. Weaver, Medical Director</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                                             |                                                                                                                                      | 23D. ADDRESS<br><b>US PHS Hospital, Balto, Md.</b>                                                                                                                                                                                                                                                                      |                                                           |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                  | 24B. DATE<br><b>8-13-70</b>                                                                                                                                 |                                                                                                                                      | 24C. NAME OF CEMETERY or CREMATORY<br><b>Baltimore National</b>                                                                                                                                                                                                                                                         |                                                           |
| 24D. LOCATION<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 24E. LOCATION<br><b>Md.</b>                                                                                                                                 |                                                                                                                                      | 24F. LOCATION<br><b>Md.</b>                                                                                                                                                                                                                                                                                             |                                                           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>AUG 11 1970</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>                                                                                                     |                                                                                                                                      | 25C. FUNERAL DIRECTOR<br><b>H. W. Jenkins &amp; Sons Co.</b>                                                                                                                                                                                                                                                            |                                                           |
| 25D. ADDRESS<br><b>4905 York Road Balto., Md. 21211</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                                             |                                                                                                                                      |                                                                                                                                                                                                                                                                                                                         |                                                           |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                             |                                                                                       | REG. NO. <u>70 7987</u>                                                     |                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <span><u>H-500</u></span> <span><u>70 7987</u></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>                                                                                                                                                                                     |                      |                                                                                                                                                             |                                                                                       |                                                                             |                                                                                               |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                              |                      | 1. NAME OF DECEASED<br>(Type or Print)                                                                                                                      |                                                                                       | 2. DATE AND HOUR OF DEATH                                                   |                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                        |                      | <u>HANN, HARRY LEE</u>                                                                                                                                      |                                                                                       | <u>AUGUST - 9 - 1970 9:15 P. M.</u>                                         |                                                                                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                 |                      |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |                                                                             |                                                                                               |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>37 MERCY HOSPITAL</u>                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                             | A. STATE <u>MD</u><br>B. COUNTY <u>902</u>                                            |                                                                             |                                                                                               |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                   |                      |                                                                                                                                                             | C. CITY OR TOWN<br><u>BALTO.</u>                                                      |                                                                             | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                        |                      |                                                                                                                                                             | E. STREET AND NUMBER<br><u>1512 E 33rd ST.</u>                                        |                                                                             |                                                                                               |
| 5. SEX<br><u>M</u>                                                                                                                                                                                                                                                                                                                                     | 6. RACE<br><u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><u>8-21-16</u>                                                    | 9. AGE (In years last birthday)<br><u>53</u>                                | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>SALES</u>                                                                                                                                                                                                                                            |                      | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>HEARING AID</u>                                                                                                     |                                                                                       | 11. BIRTHPLACE (State or foreign country)<br><u>MD.</u>                     |                                                                                               |
| 13. FATHER'S NAME<br><u>HARRY H. HANN</u>                                                                                                                                                                                                                                                                                                              |                      | 14. MOTHER'S MAIDEN NAME<br><u>IRENE L. SMITH</u>                                                                                                           |                                                                                       | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                  |                                                                                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]<br><u>No</u>                                                                                                                                                                                                                                  |                      | 16. SOCIAL SECURITY NO.<br><u>212-07-2317</u>                                                                                                               |                                                                                       | 17. INFORMANT<br><u>HARRY H. HANN</u>                                       |                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                        |                      |                                                                                                                                                             |                                                                                       | ADDRESS<br><u>ABOVE</u>                                                     |                                                                                               |
| 18. <u>5-62-11</u> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |                      |                                                                                                                                                             |                                                                                       |                                                                             |                                                                                               |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><u>ACUTE SEPTICEMIA</u>                                                                                                                                                                                                                                                                              |                      |                                                                                                                                                             |                                                                                       |                                                                             |                                                                                               |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                                                                                                           |                      |                                                                                                                                                             |                                                                                       |                                                                             |                                                                                               |
| ANTECEDENT CAUSES                                                                                                                                                                                                                                                                                                                                      |                      |                                                                                                                                                             |                                                                                       |                                                                             |                                                                                               |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause [At stating the UNDERLYING CONDITION last]                                                                                                                                                                                                                                              |                      |                                                                                                                                                             |                                                                                       |                                                                             |                                                                                               |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>LOCALIZED BOWEL WALL ABSCESS</u>                                                                                                                                                                                                                                                             |                      |                                                                                                                                                             |                                                                                       |                                                                             |                                                                                               |
| (B) DUE TO, OR AS A CONSEQUENCE OF:<br><u>PERFORATED COLON DIVERTICULUM</u>                                                                                                                                                                                                                                                                            |                      |                                                                                                                                                             |                                                                                       |                                                                             |                                                                                               |
| (C) <u>ADVANCED COR PULMONALE</u>                                                                                                                                                                                                                                                                                                                      |                      |                                                                                                                                                             |                                                                                       |                                                                             |                                                                                               |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><u>ADVANCED COR PULMONALE</u>                                                                                                                                                                                |                      |                                                                                                                                                             |                                                                                       |                                                                             |                                                                                               |
| 19A. DATE OF OPERATION<br><u>2</u>                                                                                                                                                                                                                                                                                                                     |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                       | 20A. AUTOPSY? (Yes or No)<br><u>YES</u>                                     |                                                                                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                      |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                       | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location) |                                                                                               |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                           |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                       | 21F. HOW DID INJURY OCCUR?                                                  |                                                                                               |
| 22. I certify that (N) (this hospital) attended the deceased from <u>AUGUST - 9 - 1970</u> to <u>AUGUST - 9 - 1970</u> that (N) (we) last saw the deceased alive on <u>AUGUST - 9 - 1970</u> and that (N) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (N) (We) (did) (did not) view the body after death. |                      |                                                                                                                                                             |                                                                                       |                                                                             |                                                                                               |
| 23A. SIGNATURE<br><u>Joseph Notarangelo M.D.</u>                                                                                                                                                                                                                                                                                                       |                      |                                                                                                                                                             |                                                                                       | 23B. DATE SIGNED<br><u>AUGUST - 10 - 1970</u>                               |                                                                                               |
| 23C. PHYSICIAN'S NAME (Type)<br><u>JOSEPH NOTARANGELO M.D.</u>                                                                                                                                                                                                                                                                                         |                      |                                                                                                                                                             |                                                                                       | 23D. ADDRESS<br><u>301 ST. PAUL PLACE - MERCY HOSPITAL</u>                  |                                                                                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                              |                      | 24B. DATE<br><u>8-13-70</u>                                                                                                                                 |                                                                                       | 24C. NAME of CEMETERY or CREMATORY<br><u>Parkwood</u>                       |                                                                                               |
| 24D. LOCATION<br><u>Parkville</u>                                                                                                                                                                                                                                                                                                                      |                      | 24E. CITY, TOWN, OR COUNTY<br><u>Md.</u>                                                                                                                    |                                                                                       | 24F. STATE<br><u>Md.</u>                                                    |                                                                                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>AUG 11 1970</u>                                                                                                                                                                                                                                                                                                  |                      | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor, R.D.</u>                                                                                                     |                                                                                       | 25C. FUNERAL DIRECTOR<br><u>H.W. Jenkins &amp; Sons Co., Balto., Md.</u>    |                                                                                               |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department                                                                                                                                                                                                                                                                                                                                                                                                                                         |           |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                        | REG. NO.                                                                 |                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|---------------------------------------------------------|
| C-462 70 7988                                                                                                                                                                                                                                                                                                                                                                                                                                                            |           | BIRTH NO.                                                                                                                                                   |                                                                                                                                                                                                                                                                                                        | 70 7988                                                                  |                                                         |
| 1. NAME OF DECEASED<br>(Type or Print) Octavius (Ollie) W. Clark                                                                                                                                                                                                                                                                                                                                                                                                         |           |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br>Aug. 10, 1970 8 <sup>20</sup> A.M.                                                                                                                                                                                                                                        |                                                                          |                                                         |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>00 4208 N. Charles Street                                                                                                                                                                                                                                                                     |           |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE Maryland<br>B. COUNTY 1201<br>C. CITY OR TOWN Baltimore<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 4208 N. Charles Street |                                                                          |                                                         |
| 5. SEX M                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6. RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-31-1886                                                                                                                                                                                                                                                                             | 9. AGE (In years last birthday) 84                                       | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret't. Sales-Appraiser                                                                                                                                                                                                                                                                                                                                                       |           | 10B. KIND OF BUSINESS OR INDUSTRY Real Estate                                                                                                               | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland                                                                                                                                                                                                                                          |                                                                          | 12. CITIZEN OF WHAT COUNTRY? U.S.A.                     |
| 13. FATHER'S NAME Robert M. Clark                                                                                                                                                                                                                                                                                                                                                                                                                                        |           |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME Amelia Goldhammer                                                                                                                                                                                                                                                             |                                                                          |                                                         |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No                                                                                                                                                                                                                                                                                                                                                              |           | 16. SOCIAL SECURITY NO. 213-03-5252                                                                                                                         | 17. INFORMANT ADDRESS Mr. Joseph Harlan 700 Title Bldg.                                                                                                                                                                                                                                                |                                                                          |                                                         |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Arteriosclerotic Heart Disease<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>Soul-Cholesterol<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF: |           |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Many years<br>Sudden death                                                                                                                                                                                                                             |                                                                          |                                                         |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                   |           |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                        |                                                                          |                                                         |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                   |           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                                                                        | 20A. AUTOPSY? (Yes or No) No                                             |                                                         |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                    |           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                                                                        | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                         |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)                                                                                                                                                                                                                                                                                                                                                                                                                |           | 21E. INJURY OCCURRED<br>White AI <input type="checkbox"/> Not White At Work <input type="checkbox"/>                                                        |                                                                                                                                                                                                                                                                                                        | 21F. HOW DID INJURY OCCUR?                                               |                                                         |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 6 to Aug 10 1970 that (I) (we) last saw the deceased alive on Aug 10 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. Time of death 8 <sup>20</sup> am                                                                                                                                |           |                                                                                                                                                             |                                                                                                                                                                                                                                                                                                        |                                                                          |                                                         |
| 23A. SIGNATURE<br>Dr. George McLean                                                                                                                                                                                                                                                                                                                                                                                                                                      |           |                                                                                                                                                             | 23B. DATE SIGNED<br>Aug 11-70                                                                                                                                                                                                                                                                          |                                                                          | 23C. PHYSICIAN'S NAME (Type) Dr. George McLean          |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                                                                                                                                                          |           |                                                                                                                                                             | 24B. DATE 8-12-70                                                                                                                                                                                                                                                                                      |                                                                          | 24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery |
| 24D. LOCATION (City, town, or county) Baltimore, Md.                                                                                                                                                                                                                                                                                                                                                                                                                     |           |                                                                                                                                                             | 25A. DATE REC'D BY HEALTH DEPT. AUG 11 1970                                                                                                                                                                                                                                                            |                                                                          |                                                         |
| 25B. NAME OF REGISTRAR Robert E. Jenkins, Jr.                                                                                                                                                                                                                                                                                                                                                                                                                            |           |                                                                                                                                                             | 25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212                                                                                                                                                                                                                        |                                                                          |                                                         |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

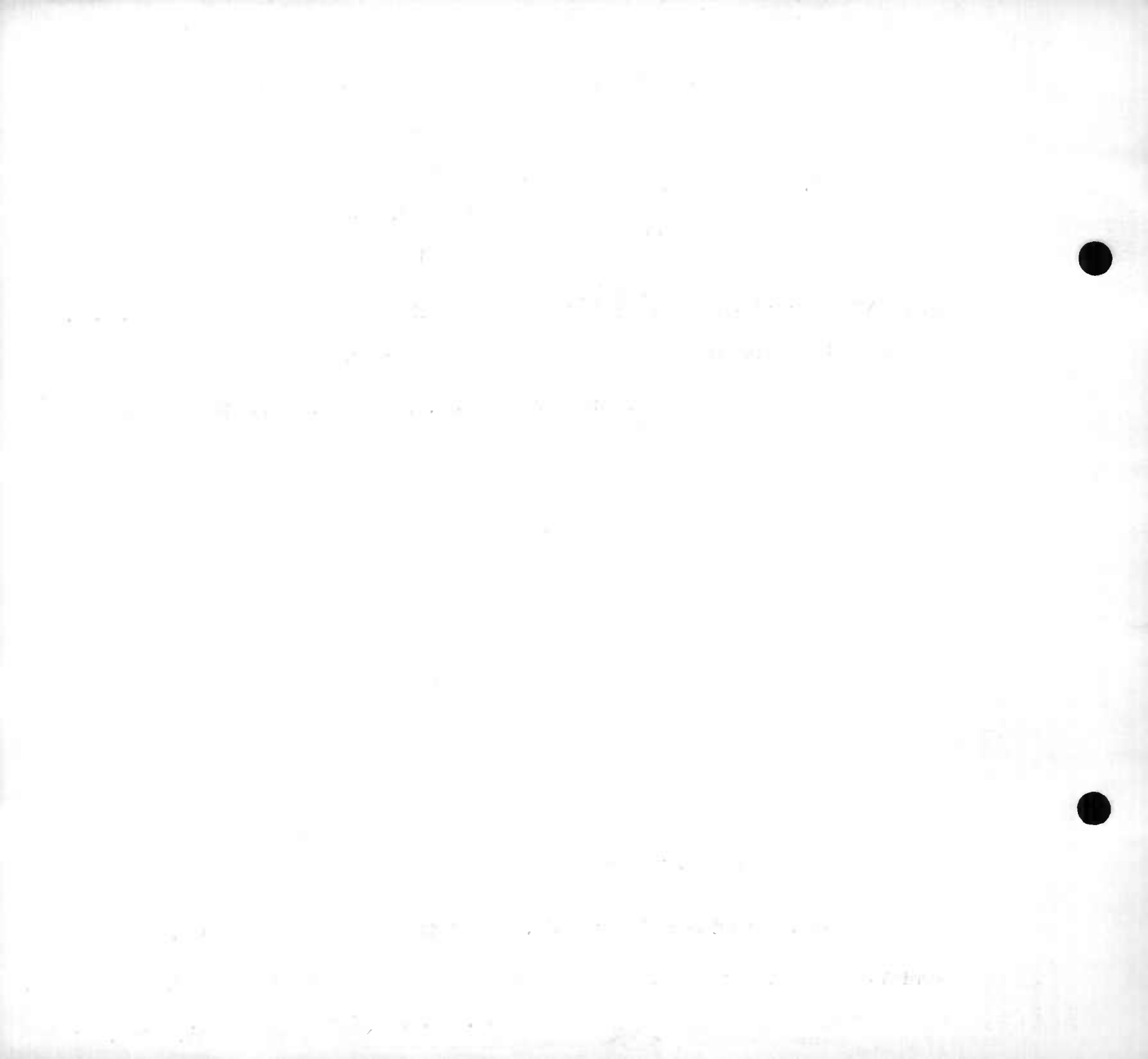
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                            |                                                                                                                                      | Registered No. <span style="background-color: black; color: black;">[REDACTED]</span>                                                          |                                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| BIRTH NO. <span style="font-size: 2em;">70 7989</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                     | <b>CERTIFICATE OF DEATH</b>                                                                                |                                                                                                                                      | 70 7989                                                                                                                                        |                                                                                                                                    |
| M.E. CASE NO. <span style="font-size: 2em;">1</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                     |                                                                                                            |                                                                                                                                      |                                                                                                                                                |                                                                                                                                    |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.5em;">MELVIN Mr ELLEN E</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                     |                                                                                                            | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.5em;">8/8/70</span> <span style="font-size: 1.5em;">3:25 PM</span>            |                                                                                                                                                |                                                                                                                                    |
| 3. PLACE OF DEATH IN BALTIMORE/MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                     |                                                                                                            | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                                |                                                                                                                                                |                                                                                                                                    |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><span style="font-size: 1.5em;">MD GENERAL HOSPITAL</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                     |                                                                                                            | A. STATE <span style="font-size: 1.5em;">Md</span> B. COUNTY <span style="font-size: 1.5em;">2714</span>                             |                                                                                                                                                |                                                                                                                                    |
| (If not in hospital or institution, give street address or location)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                     |                                                                                                            | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><span style="font-size: 1.5em;">Baltimore</span>          |                                                                                                                                                |                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                     |                                                                                                            | D. STREET ADDRESS (If rural, give location)<br><span style="font-size: 1.5em;">4401 Roland Ave.</span>                               |                                                                                                                                                |                                                                                                                                    |
| 5. SEX<br><span style="font-size: 1.5em;">F</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 6. RACE<br><span style="font-size: 1.5em;">W</span> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><span style="font-size: 1.5em;">WIDOWED</span> | 8. DATE OF BIRTH<br><span style="font-size: 1.5em;">10-18-97</span>                                                                  | 9. AGE (In years last birthday)<br><span style="font-size: 1.5em;">72</span>                                                                   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                                                          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.5em;">Home Housewife</span>                                                                                                                                                                                                                                                                                                                                                                                                     |                                                     |                                                                                                            | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.5em;">Penna.</span>                                           |                                                                                                                                                | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.5em;">U.S.A</span>                                                       |
| 13. FATHER'S NAME<br><span style="font-size: 1.5em;">Robert Eisinger</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                     |                                                                                                            | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.5em;">Mary E. Owen</span>                                                      |                                                                                                                                                |                                                                                                                                    |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.5em;">No</span>                                                                                                                                                                                                                                                                                                                                                                                                    |                                                     |                                                                                                            | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.5em;">215-42-9262</span>                                                        |                                                                                                                                                | 17. INFORMANT<br><span style="font-size: 1.5em;">Brother</span> ADDRESS<br><span style="font-size: 1.5em;">5057 Winton Ave.</span> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><span style="font-size: 1.5em;">Pneumonia, lobar, CHF - ASCVD</span>                                                                                                                                                                                                                                                                               |                                                     |                                                                                                            | CAUSE OF DEATH<br>(A) DUE TO<br><span style="font-size: 1.5em;">CHF</span>                                                           |                                                                                                                                                | INTERVAL BETWEEN ONSET AND DEATH<br><span style="font-size: 1.5em;">5 days</span>                                                  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><span style="font-size: 1.5em;">Old age</span>                                                                                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                            | (B) DUE TO                                                                                                                           |                                                                                                                                                |                                                                                                                                    |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><span style="font-size: 1.5em;">Arteriosclerotic cerebral vascular disease</span>                                                                                                                                                                                                                                                                                                                                                      |                                                     |                                                                                                            | (C) DUE TO                                                                                                                           |                                                                                                                                                | <span style="font-size: 1.5em;">Generalized arteriosclerosis</span>                                                                |
| 19A. DATE OF OPERATION<br><span style="font-size: 1.5em;">2</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                           |                                                                                                                                      | 20A. AUTOPSY? (Yes or No)<br><span style="font-size: 1.5em;">Yes</span>                                                                        |                                                                                                                                    |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                   |                                                                                                                                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><span style="font-size: 1.5em;">Yes</span>                         |                                                                                                                                    |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>     |                                                                                                                                      | 21F. HOW DID INJURY OCCUR?                                                                                                                     |                                                                                                                                    |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">8-02-</span> 19 <span style="font-size: 1.5em;">70</span> to <span style="font-size: 1.5em;">8-08</span> 19 <span style="font-size: 1.5em;">70</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">8-08</span> 19 <span style="font-size: 1.5em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                                     |                                                                                                            |                                                                                                                                      |                                                                                                                                                |                                                                                                                                    |
| 23A. SIGNATURE<br><span style="font-size: 1.5em;">M. G. MARENGA</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                     |                                                                                                            | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                                                                                                                                                | 23B. DATE SIGNED<br><span style="font-size: 1.5em;">8/8/70</span>                                                                  |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.5em;">B. G. MARENGA</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                     |                                                                                                            | 23D. ADDRESS<br><span style="font-size: 1.5em;">MGM.</span>                                                                          |                                                                                                                                                |                                                                                                                                    |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.5em;">Burial</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                     | 24B. DATE<br><span style="font-size: 1.5em;">8-12-70</span>                                                |                                                                                                                                      | 24C. NAME OF CEMETERY or CREMATORY<br><span style="font-size: 1.5em;">Loudon Park</span>                                                       |                                                                                                                                    |
| 24D. LOCATION<br><span style="font-size: 1.5em;">Baltimore</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                     | (City, town, or county)                                                                                    |                                                                                                                                      | (State)<br><span style="font-size: 1.5em;">Md.</span>                                                                                          |                                                                                                                                    |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.5em;">AUG 11 1970</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                     | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.5em;">Robert E. Taylor M.D.</span>                     |                                                                                                                                      | 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.5em;">Harry W. Jenkins</span> ADDRESS<br><span style="font-size: 1.5em;">Balto., Md.</span> |                                                                                                                                    |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

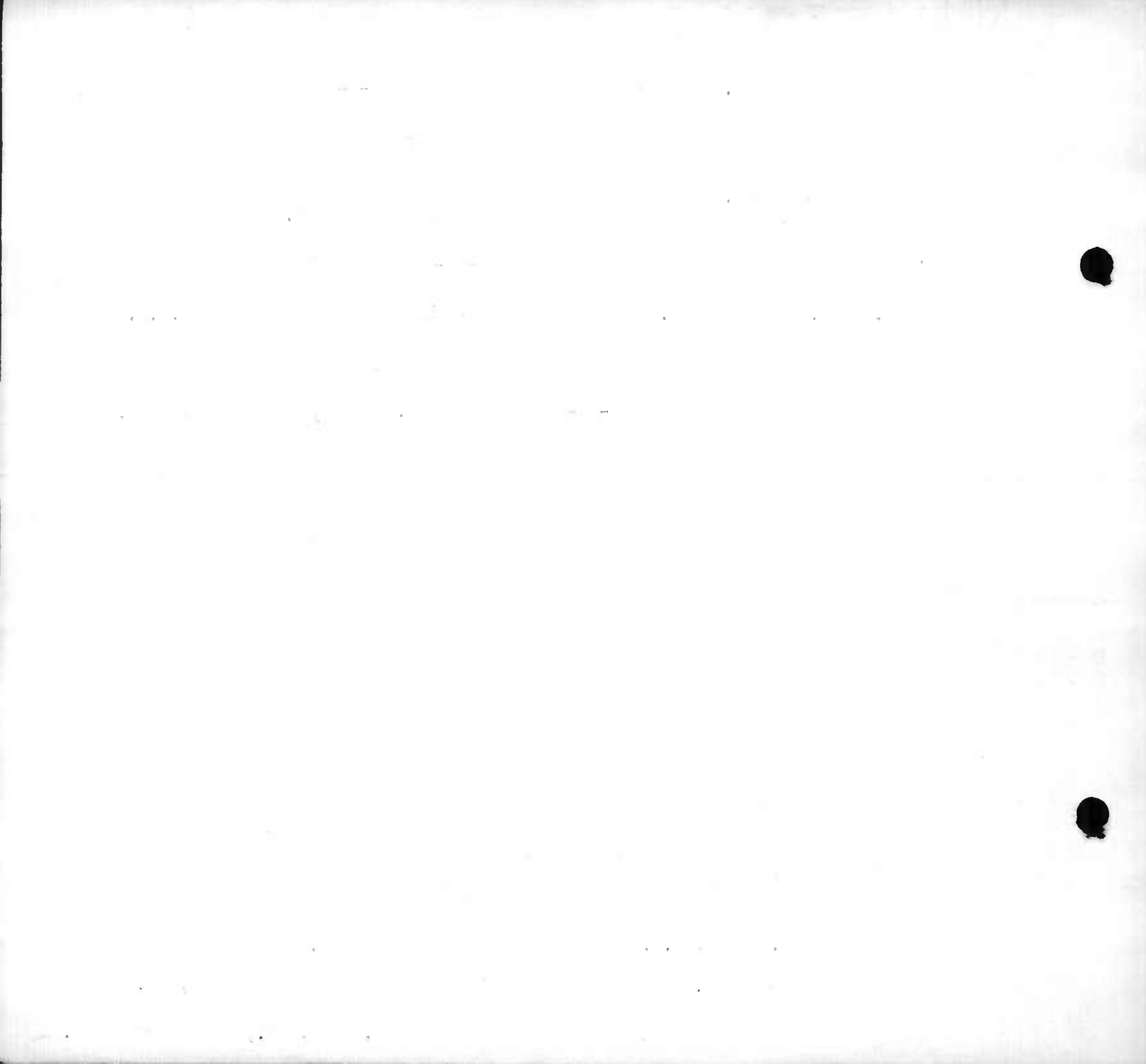
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                     |                                                                                                                                                             |                                                                                                                                                                                                                                                       | REG. NO. <span style="font-size: 1.5em;">70 7990</span>                                                 |                                                                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                     |                                                                                                                                                             |                                                                                                                                                                                                                                                       |                                                                                                         |                                                                                                                                                       |
| BIRTH NO. <span style="font-size: 1.5em;">B-630</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                     | 70 7990                                                                                                                                                     |                                                                                                                                                                                                                                                       |                                                                                                         |                                                                                                                                                       |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">Harry A. Barrett</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                     |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.2em;">Aug. 6, 1970</span> <span style="float: right;">4:30 P.M.</span>                                                                                                                         |                                                                                                         |                                                                                                                                                       |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br><span style="font-size: 1.2em;">5003 St. Albans Way</span>                                                                                                                                                                                                                                                                                                          |                                                     |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <span style="font-size: 1.2em;">Maryland</span><br>B. COUNTY <span style="font-size: 1.5em;">2712</span>                                            |                                                                                                         |                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                     |                                                                                                                                                             | C. CITY OR TOWN<br><span style="font-size: 1.2em;">Baltimore</span>                                                                                                                                                                                   |                                                                                                         | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                     |                                                                                                                                                             | E. STREET AND NUMBER<br><span style="font-size: 1.2em;">5003 St. Albans Way</span>                                                                                                                                                                    |                                                                                                         |                                                                                                                                                       |
| 5. SEX<br><span style="font-size: 1.2em;">M</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6. RACE<br><span style="font-size: 1.2em;">W</span> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><span style="font-size: 1.2em;">3-20-1904</span>                                                                                                                                                                                  | 9. AGE (In years last birthday)<br><span style="font-size: 1.2em;">66</span>                            | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                                                                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">Ret'd Vice President Barrett Office</span>                                                                                                                                                                                                                                                                                                                                                                          |                                                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><span style="font-size: 1.2em;">Service</span>                                                                         |                                                                                                                                                                                                                                                       | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">Baltimore, Maryland</span> |                                                                                                                                                       |
| 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">U.S.A.</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                     | 13. FATHER'S NAME<br><span style="font-size: 1.2em;">Frederick Barrett</span>                                                                               |                                                                                                                                                                                                                                                       | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">Ida Hollenshade</span>                      |                                                                                                                                                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">No</span>                                                                                                                                                                                                                                                                                                                                                                                              |                                                     | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.2em;">218-12-2935</span>                                                                               |                                                                                                                                                                                                                                                       | 17. INFORMANT<br><span style="font-size: 1.2em;">Mrs. Nancy R. Barrett</span>                           |                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                     | ADDRESS<br><span style="font-size: 1.2em;">Same</span>                                                                                                      |                                                                                                                                                                                                                                                       |                                                                                                         |                                                                                                                                                       |
| 18. <span style="font-size: 1.5em;">410.9 I</span> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                     |                                                                                                                                                             |                                                                                                                                                                                                                                                       |                                                                                                         |                                                                                                                                                       |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                                 |                                                     |                                                                                                                                                             | (A) IMMEDIATE CAUSE<br><span style="font-size: 1.5em;">acute myocardial infarction</span><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) <span style="font-size: 1.5em;">art rel cv disease</span><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><br><span style="font-size: 1.5em;">15 min</span><br><br><span style="font-size: 1.5em;">10+yr</span> |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                                                                                                                                                                                                                             |                                                     |                                                                                                                                                             |                                                                                                                                                                                                                                                       |                                                                                                         |                                                                                                                                                       |
| 19A. DATE OF OPERATION<br><span style="font-size: 1.2em;">0</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                                                                                                                       | 20A. AUTOPSY? (Yes or No)<br><span style="font-size: 1.2em;">No</span>                                  |                                                                                                                                                       |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                     |                                                                                                                                                             |                                                                                                                                                                                                                                                       |                                                                                                         |                                                                                                                                                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><span style="font-size: 1.2em;">No</span>                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                                                                                                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                |                                                                                                                                                       |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                                                                                                                       | 21F. HOW DID INJURY OCCUR?                                                                              |                                                                                                                                                       |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">5/3</span> 19 <span style="font-size: 1.2em;">56</span> to <span style="font-size: 1.2em;">8/6</span> 19 <span style="font-size: 1.2em;">70</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">8/6</span> 19 <span style="font-size: 1.2em;">70</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                                     |                                                                                                                                                             |                                                                                                                                                                                                                                                       |                                                                                                         |                                                                                                                                                       |
| 23A. SIGNATURE<br><span style="font-size: 1.5em;">Maurice Feldman</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                     | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">8/7/70</span>                                                                                           |                                                                                                                                                                                                                                                       |                                                                                                         |                                                                                                                                                       |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.2em;">Dr. Maurice Feldman, Jr.</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                     | 23D. ADDRESS<br><span style="font-size: 1.2em;">6610 Cross Country Blvd.</span>                                                                             |                                                                                                                                                                                                                                                       |                                                                                                         |                                                                                                                                                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">Burial</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                     | 24B. DATE<br><span style="font-size: 1.2em;">8-10-70</span>                                                                                                 |                                                                                                                                                                                                                                                       | 24C. NAME OF CEMETERY OR CREMATORY<br><span style="font-size: 1.2em;">Oaklawn Cemetery</span>           |                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                     | 24D. LOCATION (City, town, or county)<br><span style="font-size: 1.2em;">Baltimore County,</span>                                                           |                                                                                                                                                                                                                                                       | (State)<br><span style="font-size: 1.2em;">Md.</span>                                                   |                                                                                                                                                       |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.5em;">AUG 11 1970</span>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                     | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">Robert E. Farley, Jr.</span>                                                                      |                                                                                                                                                                                                                                                       | 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.2em;">H. W. Jenkins &amp; Sons Co.</span>            |                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                     | ADDRESS<br><span style="font-size: 1.2em;">4905 York Road Balto., Md. 21212</span>                                                                          |                                                                                                                                                                                                                                                       |                                                                                                         |                                                                                                                                                       |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

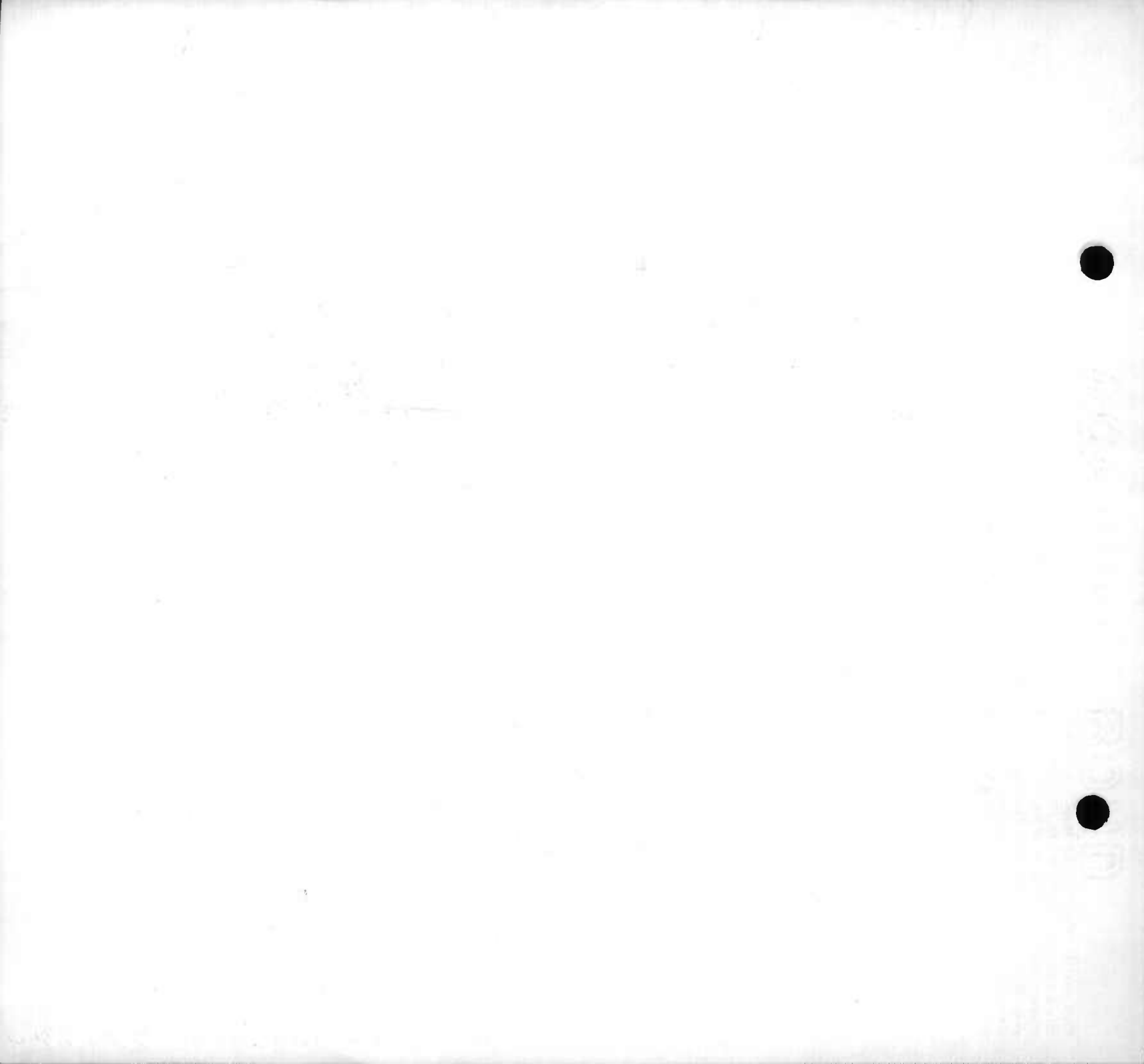
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                             |                                                                                                                                                             |                                    | 70 7991                                                                               |                        | REG. NO. 70 7991                                                                              |                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------------------------------------|------------------------|-----------------------------------------------------------------------------------------------|------------------------|
| BIRTH NO. <u>J-525</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                             |                                                                                                                                                             |                                    | 70 7991                                                                               |                        | CERTIFICATE OF DEATH                                                                          |                        |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Holger B. Jensen</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                             |                                                                                                                                                             |                                    | 2. DATE AND HOUR OF DEATH<br><u>8-8-70</u>                                            |                        | <u>7:00 A.</u> M.                                                                             |                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                             |                                                                                                                                                             |                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |                        |                                                                                               |                        |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>4140 Eierman Ave.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             |                                                                                                                                                             |                                    | A. STATE<br><u>Maryland</u>                                                           |                        | B. COUNTY<br><u>2731</u>                                                                      |                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             |                                                                                                                                                             |                                    | C. CITY OR TOWN<br><u>Baltimore</u>                                                   |                        | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             |                                                                                                                                                             |                                    | E. STREET AND NUMBER<br><u>4140 Eierman Ave.</u>                                      |                        |                                                                                               |                        |
| 5. SEX<br><u>M.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6. RACE<br><u>Caucasian</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>5-20-94</u> | 9. AGE (In years last birthday)<br><u>76</u>                                          | 10. Under 1 Yr. Months | 11. Under 24 Hrs. Days                                                                        | 12. Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Ret. Supt.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Beth. Steel</u>                                                                                                     |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>Michigan</u>                          |                        | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                 |                        |
| 13. FATHER'S NAME<br><u>Martin Jensen</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                             |                                                                                                                                                             |                                    | 14. MOTHER'S MAIDEN NAME<br><u>Marie Johnson</u>                                      |                        |                                                                                               |                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>Yes</u> <u>WW 1</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                             | 16. SOCIAL SECURITY NO.<br><u>084-14-9301</u>                                                                                                               |                                    | 17. INFORMANT<br><u>Ruth I. Jensen, 4140 Eierman Ave.</u>                             |                        | ADDRESS                                                                                       |                        |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>4109 I</u><br><u>CAUSE OF DEATH</u><br><u>Acute Coronary Occlusion</u><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>Recurrent Coronary Artery Disease</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>II</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>_____ |                             |                                                                                                                                                             |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>stat</u><br><u>17 years</u>        |                        |                                                                                               |                        |
| 19A. DATE OF OPERATION<br><u>8-12-70</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                    | 20A. AUTOPSY? (Yes or No)                                                             |                        | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                    | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)           |                        |                                                                                               |                        |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                    | 21F. HOW DID INJURY OCCUR?                                                            |                        |                                                                                               |                        |
| 22. I certify that (1) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (1) (we) last saw the deceased alive on <u>November 5</u> 19 <u>53</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                                                                                                                                                |                             |                                                                                                                                                             |                                    |                                                                                       |                        |                                                                                               |                        |
| 23A. SIGNATURE<br><u>Melvin F. Polek, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                             |                                                                                                                                                             |                                    | 23B. DATE SIGNED<br><u>August 10, 1970</u>                                            |                        |                                                                                               |                        |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Melvin F. Polek, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                             |                                                                                                                                                             |                                    | 23D. ADDRESS<br><u>3603 Belair Rd.</u>                                                |                        |                                                                                               |                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                             | 24B. DATE<br><u>8/12/70.</u>                                                                                                                                |                                    | 24C. NAME of CEMETERY or CREMATORY<br><u>Parkwood Cemetery</u>                        |                        | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore, Md.</u>                        |                        |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>AUG 11 1970</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                             | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor, M.D.</u>                                                                                                     |                                    | 25C. FUNERAL DIRECTOR<br><u>Leonard J. Ruck, Inc.</u>                                 |                        | ADDRESS<br><u>5305 Harford Rd.</u>                                                            |                        |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                                                                                           |                                              |                                                                                                                                |                                                                                       |                             |                                                                      |                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-----------------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------|
| REG. NO. <u>70 7992</u>                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                                                                                           |                                              |                                                                                                                                |                                                                                       |                             |                                                                      |                                                                       |
| BIRTH NO. <u>J-520</u> <u>70 7992</u>                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             |                                                                                                           |                                              |                                                                                                                                |                                                                                       |                             |                                                                      |                                                                       |
| 1. NAME OF DECEASED<br>(Type or Print) <u>JONES, AIMEE H. (MRS.)</u>                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                                                                                           |                                              | 2. DATE AND HOUR OF DEATH<br><u>8/19/70 at 7:50pm</u>                                                                          |                                                                                       |                             |                                                                      |                                                                       |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                                                                                           |                                              | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                          |                                                                                       |                             |                                                                      |                                                                       |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>THE UNION MEMORIAL HOSPITAL</u><br><u>4/4</u>                                                                                                                                                                                                                                                      |                         |                                                                                                                                                             |                                                                                                           |                                              | A. STATE <u>MARYLAND</u><br>B. COUNTY <u>2759</u>                                                                              |                                                                                       |                             |                                                                      |                                                                       |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                                                                                           |                                              | C. CITY OR TOWN <u>BALTIMORE</u><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                       |                             |                                                                      |                                                                       |
| E. STREET AND NUMBER<br><u>1614, KINGSWAY ROAD, BALTIMORE MARYLAND</u>                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                                                                                           |                                              |                                                                                                                                |                                                                                       |                             |                                                                      |                                                                       |
| 5. SEX<br><u>FEMALE</u>                                                                                                                                                                                                                                                                                                                       | 6. RACE<br><u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>08/28/91</u>                                                                       | 9. AGE (In years last birthday)<br><u>78</u> | If Under 1 Yr. Months Days                                                                                                     |                                                                                       | If Under 24 Hrs. Hours Min. |                                                                      |                                                                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>RETIRED TEACHER</u>                                                                                                                                                                                                                         |                         |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY                                                                         |                                              |                                                                                                                                | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>                          |                             | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA.</u>                          |                                                                       |
| 13. FATHER'S NAME<br><u>ALFRED W. HIGGINS</u>                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><u>EMILY W. HIGGINS</u>                                                       |                                              |                                                                                                                                |                                                                                       |                             |                                                                      |                                                                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                         |                         |                                                                                                                                                             | 16. SOCIAL SECURITY NO.                                                                                   |                                              |                                                                                                                                | 17. INFORMANT <u>MRS. MARY JONES R. JONES</u><br><u>1614, Kingsway Rd. Balto. Md.</u> |                             |                                                                      |                                                                       |
| 18. <u>4367 I</u> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             |                                                                                                           |                                              |                                                                                                                                |                                                                                       |                             |                                                                      |                                                                       |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.              |                         |                                                                                                                                                             |                                                                                                           |                                              |                                                                                                                                |                                                                                       |                             |                                                                      |                                                                       |
| (A) IMMEDIATE CAUSE <u>Cerebro Vascular Accident</u><br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                                                                                           |                                              |                                                                                                                                |                                                                                       |                             |                                                                      |                                                                       |
| (B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             |                                                                                                           |                                              |                                                                                                                                |                                                                                       |                             |                                                                      |                                                                       |
| (C) _____                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             |                                                                                                           |                                              |                                                                                                                                |                                                                                       |                             |                                                                      |                                                                       |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                                        |                         |                                                                                                                                                             |                                                                                                           |                                              |                                                                                                                                |                                                                                       |                             |                                                                      |                                                                       |
| 19A. DATE OF OPERATION<br><u>0</u>                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>/</u>                                              |                                              |                                                                                                                                | 20A. AUTOPSY? (Yes or No)<br><u>No.</u>                                               |                             | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                                                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined)<br><u>/</u>                                                                                                                                                                                                                                          |                         |                                                                                                                                                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><u>/</u>      |                                              |                                                                                                                                | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><u>/</u>  |                             |                                                                      |                                                                       |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                              |                                                                                                                                | 21F. HOW DID INJURY OCCUR?<br><u>/</u>                                                |                             |                                                                      |                                                                       |
| 22. I certify that (I) (this hospital) attended the deceased from <u>08/09/70, 11:45AM</u> to <u>08/09/70, 7:50pm</u> that (I) (we) last saw the deceased alive on <u>08/09/1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |                                                                                                                                                             |                                                                                                           |                                              |                                                                                                                                |                                                                                       |                             |                                                                      |                                                                       |
| 23A. SIGNATURE<br><u>Malmoor Khan</u>                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             |                                                                                                           |                                              |                                                                                                                                |                                                                                       |                             | 23B. DATE SIGNED<br><u>08/09/70</u>                                  |                                                                       |
| 23C. PHYSICIAN'S NAME (Type)<br><u>DR. MAHMOOD ALI KHAN</u>                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                                                                                           |                                              |                                                                                                                                |                                                                                       |                             | 23D. ADDRESS<br><u>UNION MEMORIAL HOSPITAL</u>                       |                                                                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                                             | 24B. DATE<br><u>8/13/70</u>                                                                               |                                              |                                                                                                                                | 24C. NAME OF CEMETERY OR CREMATORY<br><u>MEADOWRIDGE MEM. CEM.</u>                    |                             |                                                                      | 24D. LOCATION (City, town, or county) (State)<br><u>E/Kridge, Md.</u> |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>AUG 11 1970</u>                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                                             | 25B. NAME OF REGISTRAR<br><u>Robert E. Faber, MD.</u>                                                     |                                              |                                                                                                                                | 25C. FUNERAL DIRECTOR<br><u>LEONARD J. RUCK, INC. Balto. Md.</u>                      |                             |                                                                      | ADDRESS<br><u>21214</u>                                               |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

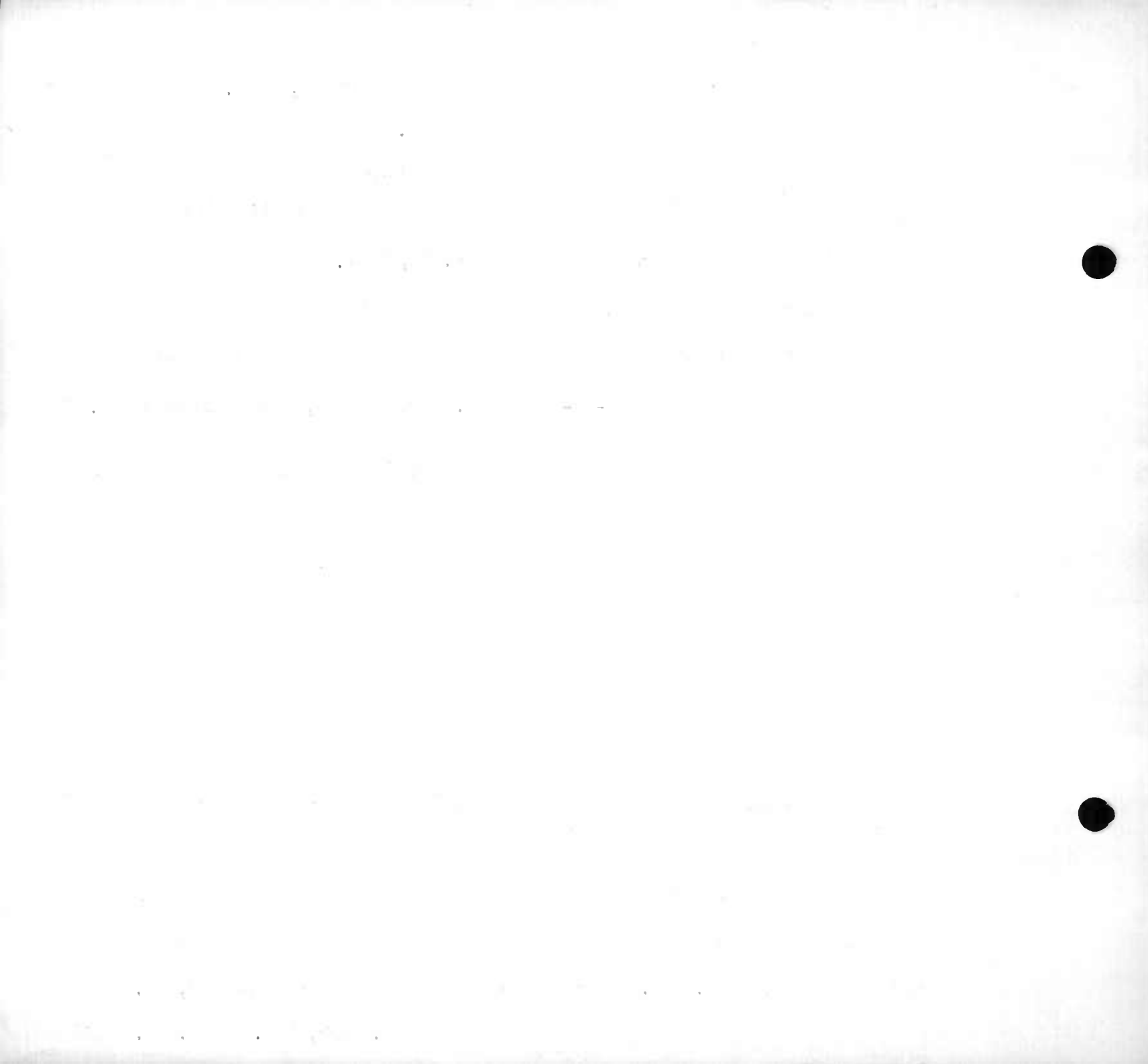
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                      |                                                                                                                                                             |                                               |                                                                                                                           |                                                       |                                                                                               |                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------|
| N-250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                      | 70 7993                                                                                                                                                     |                                               | BALTIMORE CITY HEALTH DEPARTMENT                                                                                          |                                                       | 70 7993                                                                                       |                                     |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                      |                                                                                                                                                             |                                               | CERTIFICATE OF DEATH                                                                                                      |                                                       |                                                                                               |                                     |
| 1. NAME OF DECEASED<br>(Type or Print) Robert R Nixon                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                      |                                                                                                                                                             |                                               | 2. DATE AND HOUR OF DEATH<br>8/9/70 19:20 P.M.                                                                            |                                                       |                                                                                               |                                     |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                      |                                                                                                                                                             |                                               | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE MARYLAND B. COUNTY 2734 |                                                       |                                                                                               |                                     |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>44 UNION MEMORIAL HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                      | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                        |                                               | C. CITY OR TOWN<br>BALTIMORE CITY                                                                                         |                                                       | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                      |                                                                                                                                                             |                                               | E. STREET AND NUMBER<br>5907 FIARWOOD AVE                                                                                 |                                                       |                                                                                               |                                     |
| 5. SEX<br>M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 6. RACE<br>Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>2/6/28                    | 9. AGE (In years last birthday)<br>42                                                                                     | 10. Under 1 Yr. Months Days                           | 11. Under 24 Hrs. Min.                                                                        |                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Carpenter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                                                                             | 10B. KIND OF BUSINESS OR INDUSTRY             |                                                                                                                           | 11. BIRTHPLACE (State or foreign country)<br>Maryland |                                                                                               | 12. CITIZEN OF WHAT COUNTRY?<br>USA |
| 13. FATHER'S NAME<br>Frederick Nixon                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      |                                                                                                                                                             | 14. MOTHER'S MARDEN NAME<br>Genevieve Finegan |                                                                                                                           |                                                       |                                                                                               |                                     |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service)<br>Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br>218-22-4584        |                                                                                                                           | 17. INFORMANT<br>Wife - Edna R. Nixon                 |                                                                                               | ADDRESS<br>Same                     |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ACUTE MYOCARDIAL INFARCTION<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>19A. DATE OF OPERATION<br>2/10/71<br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>20A. AUTOPSY? (Yes or No)<br>YES<br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                      |                                                                                                                                                             |                                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                              |                                                       |                                                                                               |                                     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                                  |                                                       |                                                                                               |                                     |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                               | 21F. HOW DID INJURY OCCUR?                                                                                                |                                                       |                                                                                               |                                     |
| 22. I certify that (I) (this hospital) attended the deceased from 8/9 1970 to 8/9 1970 that (I) (we) last saw the deceased alive on 8:20pm 8/9 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                                                                                                                                                                                                                                                                                                                                                                                                         |                      |                                                                                                                                                             |                                               |                                                                                                                           |                                                       |                                                                                               |                                     |
| 23A. SIGNATURE<br>Miguel Karacuschansky M.D.<br>DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                      |                                                                                                                                                             |                                               | 23B. DATE SIGNED<br>8/9/70                                                                                                |                                                       | 23C. PHYSICIAN'S NAME (Type)<br>Miguel KARACUSCHANSKY, MD<br>DEGREE                           |                                     |
| 24A. BURIAL CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                      | 24B. DATE<br>8/13/70                                                                                                                                        |                                               | 24C. NAME OF CEMETERY or CREMATORY<br>Baltimore National                                                                  |                                                       | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland                          |                                     |
| 25A. DATE REC'D BY HEALTH DEPT.<br>AUG 11 1970                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                      | 25B. NAME OF REGISTRAR<br>Robert E. Jaber, M.D.                                                                                                             |                                               | 25C. FUNERAL DIRECTOR<br>Leonard J. Ruck Inc. Baltimore, Maryland                                                         |                                                       | ADDRESS                                                                                       |                                     |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                    |               |                                                                                                                                                          |  | REG. NO. 70 7994                                                                           |                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|------------------------------------|
| BIRTH NO. 4-536                                                                                                                                                                                                                                                                                                     |               | 70 7994                                                                                                                                                  |  | BALTIMORE CITY HEALTH DEPARTMENT                                                           |                                    |
| 1. NAME OF DECEASED (Type or Print) LEON W. HENDRICKSON                                                                                                                                                                                                                                                             |               | 2. DATE AND HOUR OF DEATH August 8, 1970.                                                                                                                |  |                                                                                            |                                    |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD                                                                                                                                                                                                                                                              |               | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)                                                                    |  |                                                                                            |                                    |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                           |               | A. STATE Md.                                                                                                                                             |  | B. COUNTY                                                                                  |                                    |
| 00 3002 White Avenue                                                                                                                                                                                                                                                                                                |               | C. CITY OR TOWN Baltimore                                                                                                                                |  | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                    |
|                                                                                                                                                                                                                                                                                                                     |               | E. STREET AND NUMBER 3002 White Avenue                                                                                                                   |  |                                                                                            |                                    |
| 5. SEX Male                                                                                                                                                                                                                                                                                                         | 6. RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH Nov. 16, 1882                                                             | 9. AGE (In years last birthday) 87 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Minister                                                                                                                                                                                                        |               | 10B. KIND OF BUSINESS OR INDUSTRY Church                                                                                                                 |  | 11. BIRTHPLACE (State or foreign country) Virginia                                         | 12. CITIZEN OF WHAT COUNTRY? USA   |
| 13. FATHER'S NAME Samuel Hendrickson                                                                                                                                                                                                                                                                                |               | 14. MOTHER'S MAIDEN NAME Minerva Burns                                                                                                                   |  |                                                                                            |                                    |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No                                                                                                                                                                                                         |               | 16. SOCIAL SECURITY NO. 327-20-4218A                                                                                                                     |  | 17. INFORMANT ADDRESS Mrs. Edith Meynen, 2528 Canterbury Rd. #34                           |                                    |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)                                                                                                                     |               | CAUSE OF DEATH                                                                                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                               |                                    |
| Antecedent Causes                                                                                                                                                                                                                                                                                                   |               | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis                                                                                     |  | years                                                                                      |                                    |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                                                                                                                                                                                           |               | (B) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                      |  |                                                                                            |                                    |
| (C) DUE TO, OR AS A CONSEQUENCE OF:                                                                                                                                                                                                                                                                                 |               |                                                                                                                                                          |  |                                                                                            |                                    |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).                                                                                                                                                                                 |               |                                                                                                                                                          |  |                                                                                            |                                    |
| 19A. DATE OF OPERATION                                                                                                                                                                                                                                                                                              |               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  | 20A. AUTOPSY? (Yes or No)                                                                  |                                    |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examination)                                                                                                                                                                                                                            |               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                 |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                   |                                    |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                           |               | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |  | 21F. HOW DID INJURY OCCUR?                                                                 |                                    |
| 22. I certify that (I) (this hospital) attended the deceased from July 20 1966 to August 8 1970 that (I) (we) last saw the deceased alive on August 6 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |               |                                                                                                                                                          |  |                                                                                            |                                    |
| 23A. SIGNATURE J. Frank Supplee, Jr.                                                                                                                                                                                                                                                                                |               | 23B. DATE SIGNED 8/10/70                                                                                                                                 |  |                                                                                            |                                    |
| 23C. PHYSICIAN'S NAME (Type) J. Frank Supplee, Jr.                                                                                                                                                                                                                                                                  |               | 23D. ADDRESS 1010 St Paul St., Balt 2, Md                                                                                                                |  |                                                                                            |                                    |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                     |               | 24B. DATE 8/11/70.                                                                                                                                       |  | 24C. NAME OF CEMETERY OR CREMATORY St. Marks Cemetery                                      |                                    |
| 24D. LOCATION (City, town, or county) (State) Nottaway County, Va.                                                                                                                                                                                                                                                  |               |                                                                                                                                                          |  |                                                                                            |                                    |
| 25A. DATE REC'D BY HEALTH DEPT. AUG 11 1970                                                                                                                                                                                                                                                                         |               | 25B. NAME OF REGISTRAR Robert E. Fabe, Md.                                                                                                               |  | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214                               |                                    |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

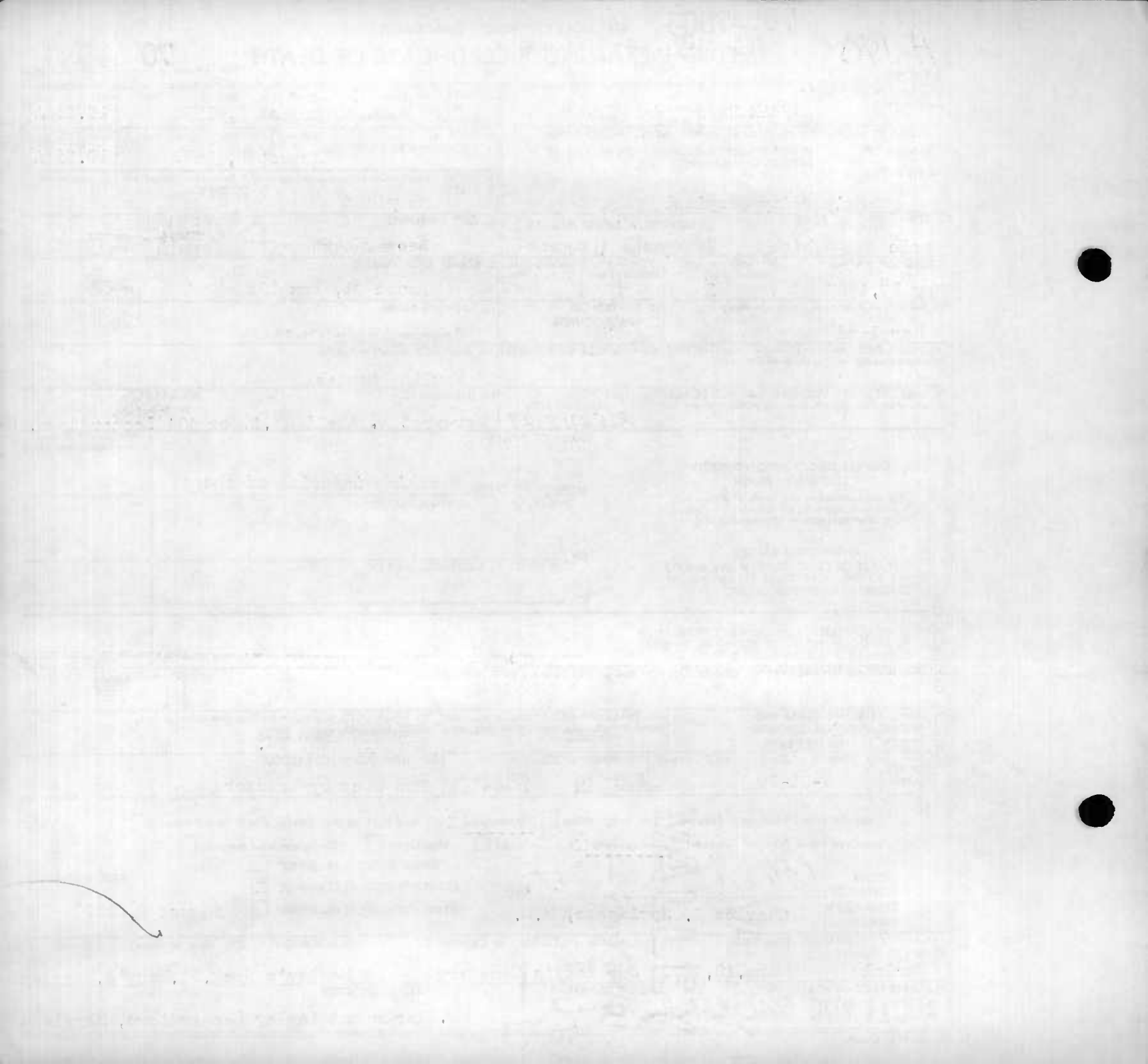
REG. NO.

70

7995

BIRTH NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) FRANCIS EDGAR ABELL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> August 8, 1970                                                                                                                                                                                                                                                                                                                                                                                              |  | Hour 10.25 A.M.                                                                                                                                             |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>38 University Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br>August 8, 1970                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | Hour 10.25 A.M.                                                                                                                                             |  |
| 6. SEX Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                  |  | 7. RACE White                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br>May 27, 1907                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                  |  | 10. AGE (In years last birthday) 63                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                       |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                  |  | 13. FATHER'S NAME<br>George Edgar Abell                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                  |  |
| 15. MOTHER'S MAIDEN NAME<br>Pauline Bowles                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 17. SOCIAL SECURITY NO.<br>215 348327                                                                                                                       |  |
| 18. INFORMANT<br>Margaret M. Abell                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                  |  | 19. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Crushing injuries of chest<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(A) IMMEDIATE CAUSE<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6800                                                                                                        |  |
| 20A. DATE OF OPERATION<br>2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 21. AUTOPSY? (Yes or No)<br>Yes                                                                                                                             |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>farm                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?<br>Leonardtown, Md. 6800                                                           |  |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br>7-31-70                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                  |  | 22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                              |  | 22F. HOW DID INJURY OCCUR?<br>Run over by tractor                                                                                                           |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE Charles S. Springate, M.D.<br>EXAMINER'S NAME (Type) Charles S. Springate, M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 9, 1970 |  |                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                             |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 24B. DATE<br>Aug. 12, 1970                       |  | 24C. NAME OF CEMETERY or CREMATORY<br>Our Lady's Cemetery                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 24D. LOCATION (City, town, or county) (State)<br>Medley's Neck, St. Mary's, Maryland                                                                        |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>AUG 11 1970                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 25B. NAME OF REGISTRAR<br>Robert E. Farber, M.D. |  | 25C. FUNERAL DIRECTOR ADDRESS<br>W. Clarke Mattingley Leonardtown, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                             |  |



**BALTIMORE CITY HEALTH DEPARTMENT**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**BIRTH NO.** 70 7996 **REG. NO.** 70 7996

**1. NAME OF DECEASED** G. Thomas Dundlow, Sr.  
 (Type or Print)

**2. DATE OF DEATH** Known ☐ Estimated ☒ 8 9 70 4:45 p. m.  
 Month Day Year Hour

**3. DATE PRONOUNCED DEAD** 8 9 70 4:45 p. m.  
 Month Day Year Hour

**4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD**  
 FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
241 S. Broadway

**5. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission)  
 A. STATE Md. B. COUNTY 202

**6. SEX** male **7. RACE** White **8. MARRIED** ☐ **NEVER MARRIED** ☐  
**WIDOWED** ☒ **DIVORCED** ☐

**9. DATE OF BIRTH** 1-1-96 **10. AGE** (In years last birthday) 74 **11. BIRTHPLACE** (State or foreign country) Virginia  
 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

**12. CITIZEN OF WHAT COUNTRY?** U.S.A. **13. FATHER'S NAME** Thomas J. Dundlow

**14A. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) Farmer **14B. KIND OF BUSINESS OR INDUSTRY** Self-employed **15. MOTHER'S MAIDEN NAME** ?

**16. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I **17. SOCIAL SECURITY NO.** 224-30-7530 **18. INFORMANT** Son: Jim B. Dunlow 1525 Leslie Rd. Dundalk, Md. ADDRESS

**19. CAUSE OF DEATH**  
412.41  
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** Arteriosclerotic cardiovascular disease  
 (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  
**(A) IMMEDIATE CAUSE** disease  
**DUE TO, OR AS A CONSEQUENCE OF:**  
**(B)** DUE TO, OR AS A CONSEQUENCE OF:  
**(C)** DUE TO, OR AS A CONSEQUENCE OF:

**II**  
**OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).**

**20A. DATE OF OPERATION** 0 **20B. CONDITION FOR WHICH OPERATION WAS PERFORMED** no **21. AUTOPSY?** (Yes or No) no

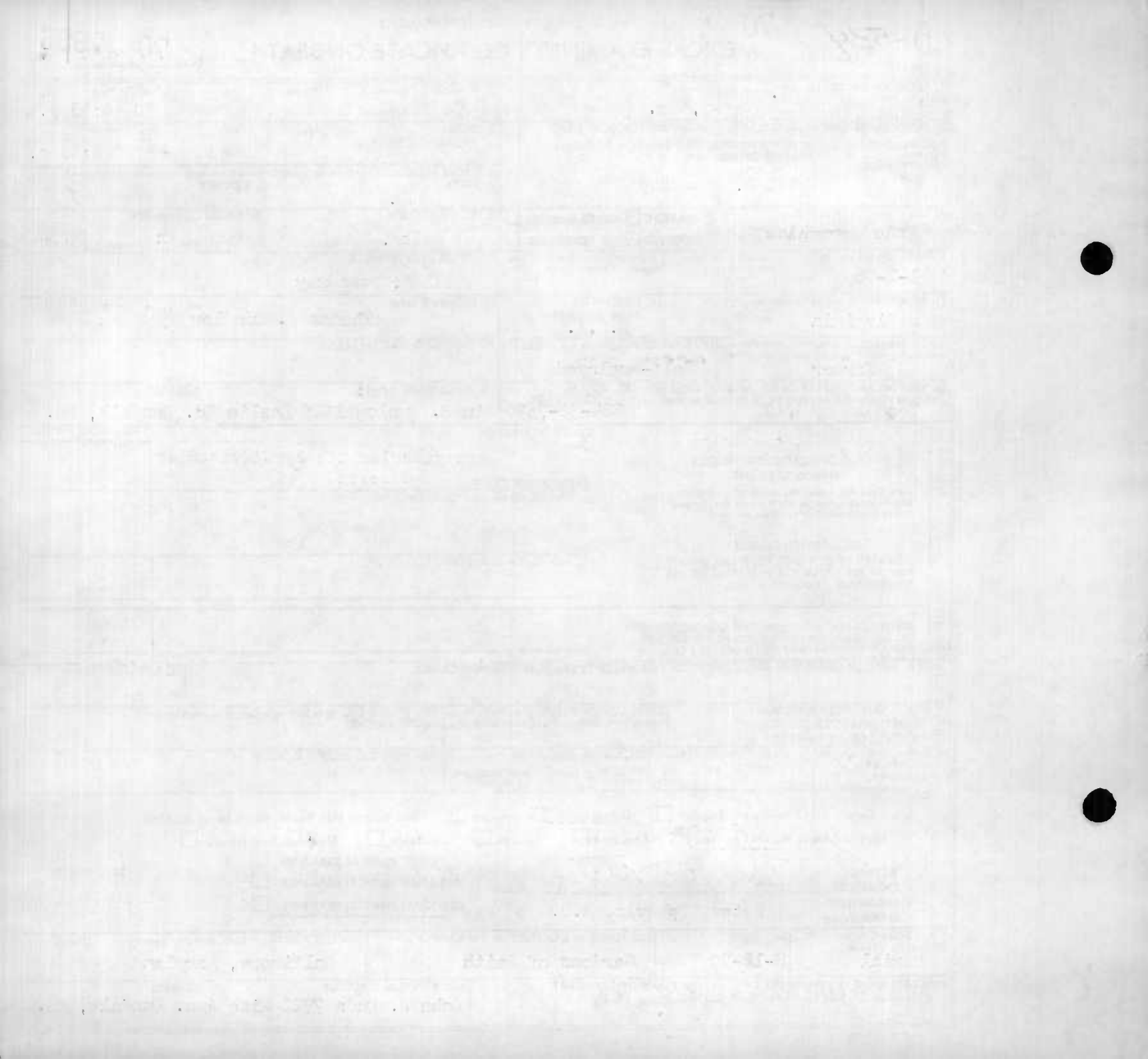
**22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.** ☐ **22B. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) no **22C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location)

**22D. TIME OF INJURY** (Month) (Day) (Year) (Hour) (Approx.) no **22E. INJURY OCCURRED** no **22F. HOW DID INJURY OCCUR?**

**23.**  
 I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐  
 ACTUAL SIGNATURE Peter Lipkovic M.D. **CHIEF MEDICAL EXAMINER** ☐  
**EXAMINER'S NAME (Type)** Peter Lipkovic, M.D. **ASSISTANT MEDICAL EXAMINER** ☐  
**ASSOCIATE MEDICAL EXAMINER** ☒ **DATE SIGNED** 8/10/70

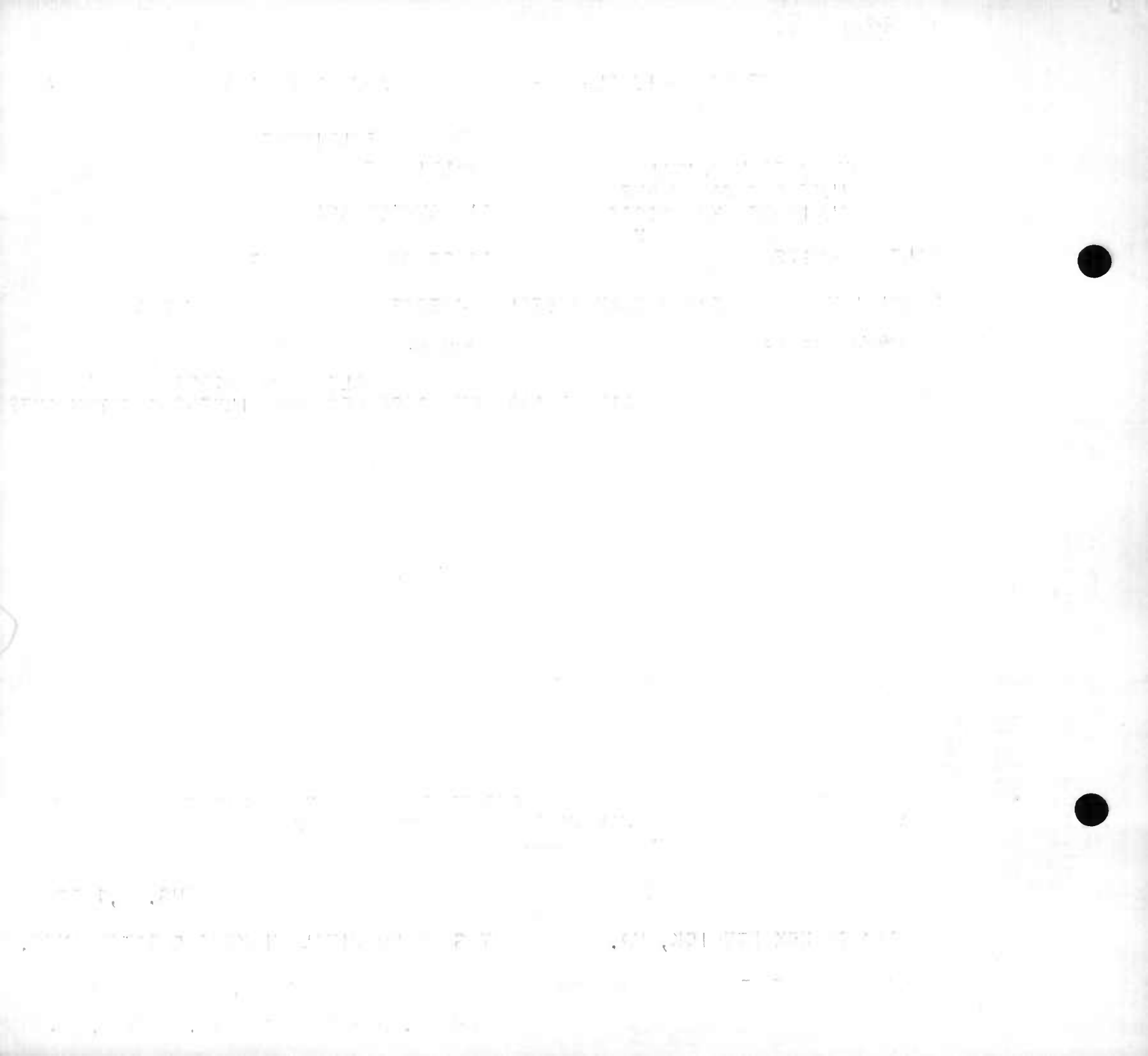
**24A. BURIAL CREMATION, REMOVAL** (Specify) Burial **24B. DATE** 8-12-70 **24C. NAME OF CEMETERY or CREMATORY** Gardens of Faith **24D. LOCATION** (City, town, or county) (State) Baltimore, Maryland

**25A. DATE REG'D BY HEALTH DEPT.** AUG 11 1970 **25B. NAME OF REGISTRAR** Robert E. Taylor, M.D. **25C. FUNERAL DIRECTOR** John J. Duda 7922 Wise Ave. Dundalk, Md. ADDRESS

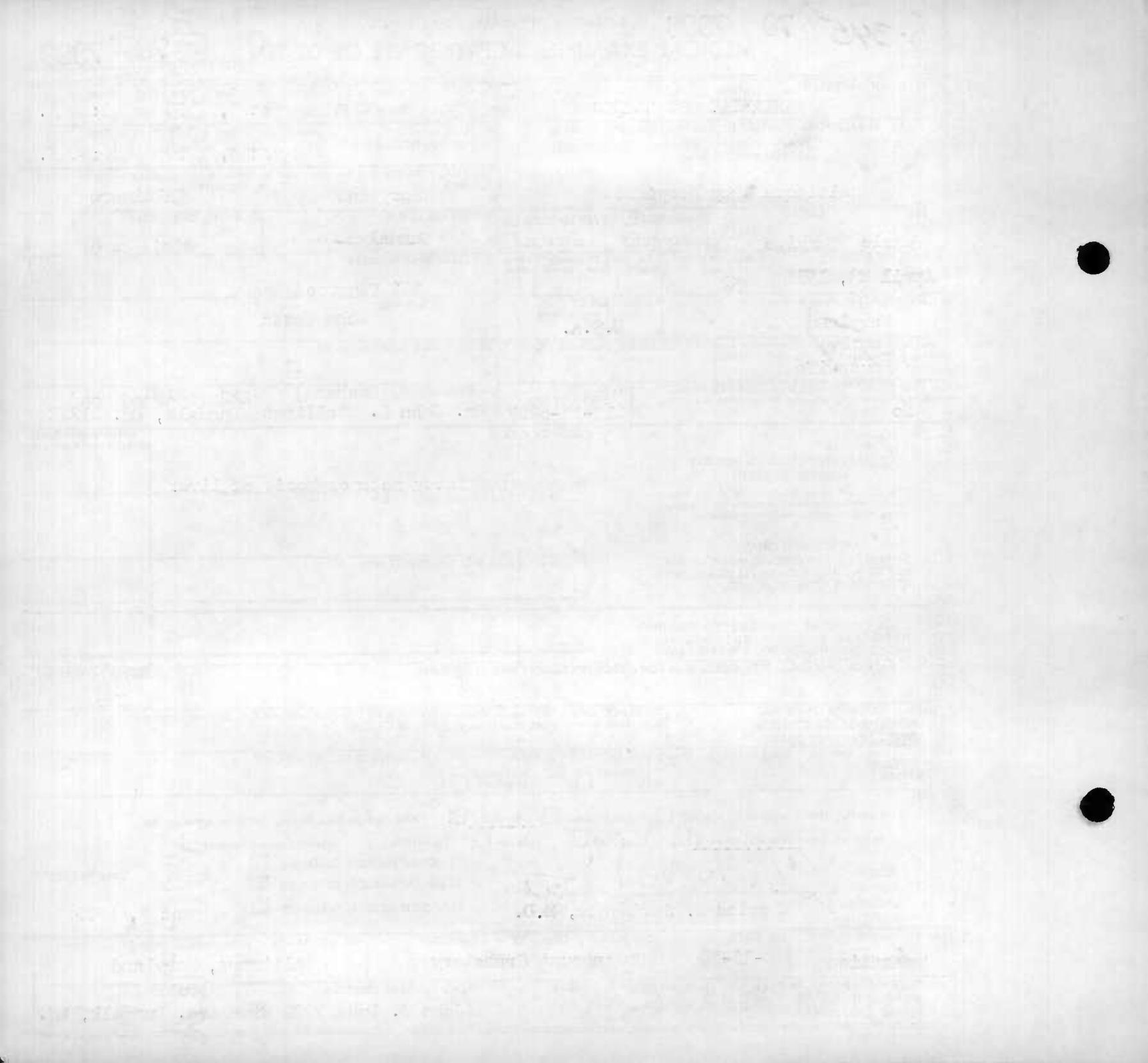


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| <p><b>BIRTH NO.</b> <span style="font-size: 1.5em;">X-320 70 7997</span></p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p>                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | <p>REG. NO. <span style="font-size: 1.5em;">70 7997</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                            |
| <p><b>1. NAME OF DECEASED</b><br/>(Type or Print) <span style="font-size: 1.2em;">XEDOS, NICHOLAS ---</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | <p><b>2. DATE AND HOUR OF DEATH</b><br/><span style="font-size: 1.2em;">AUGUST 8, 1970 4:00 A.M.</span></p>                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                            |
| <p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br/><span style="font-size: 1.2em;">40 ST AGNES HOSPITAL WILKENS &amp; CATON AVES. BALTIMORE, MD. 21229</span></p>                                                                                                                                                                                                                                                                                         |                                                                            | <p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution residence before admission)<br/>A. STATE <span style="font-size: 1.2em;">MD.</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE</span></p> <p><b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">BALTIMORE Dundalk</span> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p><b>E. STREET AND NUMBER</b><br/><span style="font-size: 1.2em;">11 OAKWOOD ROAD</span></p> |                                                                                                                            |
| <p><b>5. SEX</b><br/><span style="font-size: 1.2em;">MALE</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <p><b>6. RACE</b><br/><span style="font-size: 1.2em;">WHITE</span></p>     | <p><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br/>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                   | <p><b>8. DATE OF BIRTH</b><br/><span style="font-size: 1.2em;">12 27 95</span></p>                                         |
| <p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br/><span style="font-size: 1.2em;">MACHINIST</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | <p><b>10B. KIND OF BUSINESS OR INDUSTRY</b><br/><span style="font-size: 1.2em;">CROWN CORK &amp; SEAL</span></p>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                            |
| <p><b>11. BIRTHPLACE</b> (State or foreign country)<br/><span style="font-size: 1.2em;">GREECE</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | <p><b>12. CITIZEN OF WHAT COUNTRY?</b><br/><span style="font-size: 1.2em;">U.S.A.</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                            |
| <p><b>13. FATHER'S NAME</b><br/><span style="font-size: 1.2em;">LEON XEDOS</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | <p><b>14. MOTHER'S MAIDEN NAME</b><br/><span style="font-size: 1.2em;">Elpetha ?</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                            |
| <p><b>15. Was Deceased Ever in U. S. Armed Forces?</b><br/>(Yes, no or unknown) (If yes, give war or dates of service)<br/><span style="font-size: 1.2em;">NO</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | <p><b>16. SOCIAL SECURITY NO.</b><br/><span style="font-size: 1.2em;">213 07 1440</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                            |
| <p><b>17. INFORMANT</b> <span style="font-size: 1.2em;">BALTO. MD. 21229</span> <b>ADDRESS</b><br/><span style="font-size: 1.2em;">ST AGNES RECORDS WILKENS &amp; CATON AVES.</span></p>                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                            |
| <p><b>18. CAUSE OF DEATH</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br/>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br/><span style="font-size: 1.2em;">inferior Vena Cava Compression</span></p> <p><b>ANTECEDENT CAUSES</b><br/>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br/><span style="font-size: 1.2em;">metastatic Ca</span><br/><span style="font-size: 1.2em;">Adeno Ca of Lung.</span></p> |                                                                            | <p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                            |
| <p><b>II</b></p> <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                            |
| <p><b>19A. DATE OF OPERATION</b><br/><span style="font-size: 1.2em;">0</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | <p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                            |
| <p><b>20A. AUTOPSY?</b> (Yes or No)<br/><span style="font-size: 1.2em;">No</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | <p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                            |
| <p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)<br/><input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | <p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                            |
| <p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                            |
| <p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | <p><b>21E. INJURY OCCURRED</b><br/>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                            |
| <p><b>21F. HOW DID INJURY OCCUR?</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                            |
| <p><b>22. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <span style="font-size: 1.2em;">AUGUST 1, 1970</span> to <span style="font-size: 1.2em;">AUGUST 8, 1970</span> that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <span style="font-size: 1.2em;">AUGUST 8, 1970</span> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (We) (did) view the body after death.</p>             |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                            |
| <p><b>23A. SIGNATURE</b><br/><span style="font-size: 1.2em;">G. Patrick MD</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | <p><b>23B. DATE SIGNED</b><br/><span style="font-size: 1.2em;">AUG. 8, 1970</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                            |
| <p><b>23C. PHYSICIAN'S NAME</b> (Type)<br/><span style="font-size: 1.2em;">GEORGE RXX PATRICK, MD.</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | <p><b>23D. ADDRESS</b><br/><span style="font-size: 1.2em;">STAGNES HOSPITAL WILKENS &amp; CATON AVES.</span></p>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                            |
| <p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)<br/><span style="font-size: 1.2em;">Burial</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <p><b>24B. DATE</b><br/><span style="font-size: 1.2em;">8-11-70</span></p> | <p><b>24C. NAME OF CEMETERY OR CREMATORY</b><br/><span style="font-size: 1.2em;">Oak Lawn</span></p>                                                                                                                                                                                                                                                                                                                                                                                                         | <p><b>24D. LOCATION</b> (City, town, or county) (State)<br/><span style="font-size: 1.2em;">Baltimore, Maryland</span></p> |
| <p><b>25A. DATE REC'D BY HEALTH DEPT.</b><br/><span style="font-size: 1.2em;">AUG 11 1970</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | <p><b>25B. NAME OF REGISTRAR</b><br/><span style="font-size: 1.2em;">Robert E. Sabin, MD.</span></p>                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                            |
| <p><b>25C. FUNERAL DIRECTOR</b><br/><span style="font-size: 1.2em;">John J. Duda</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | <p><b>ADDRESS</b><br/><span style="font-size: 1.2em;">7922 Wise Ave. Dundalk, Md.</span></p>                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                            |



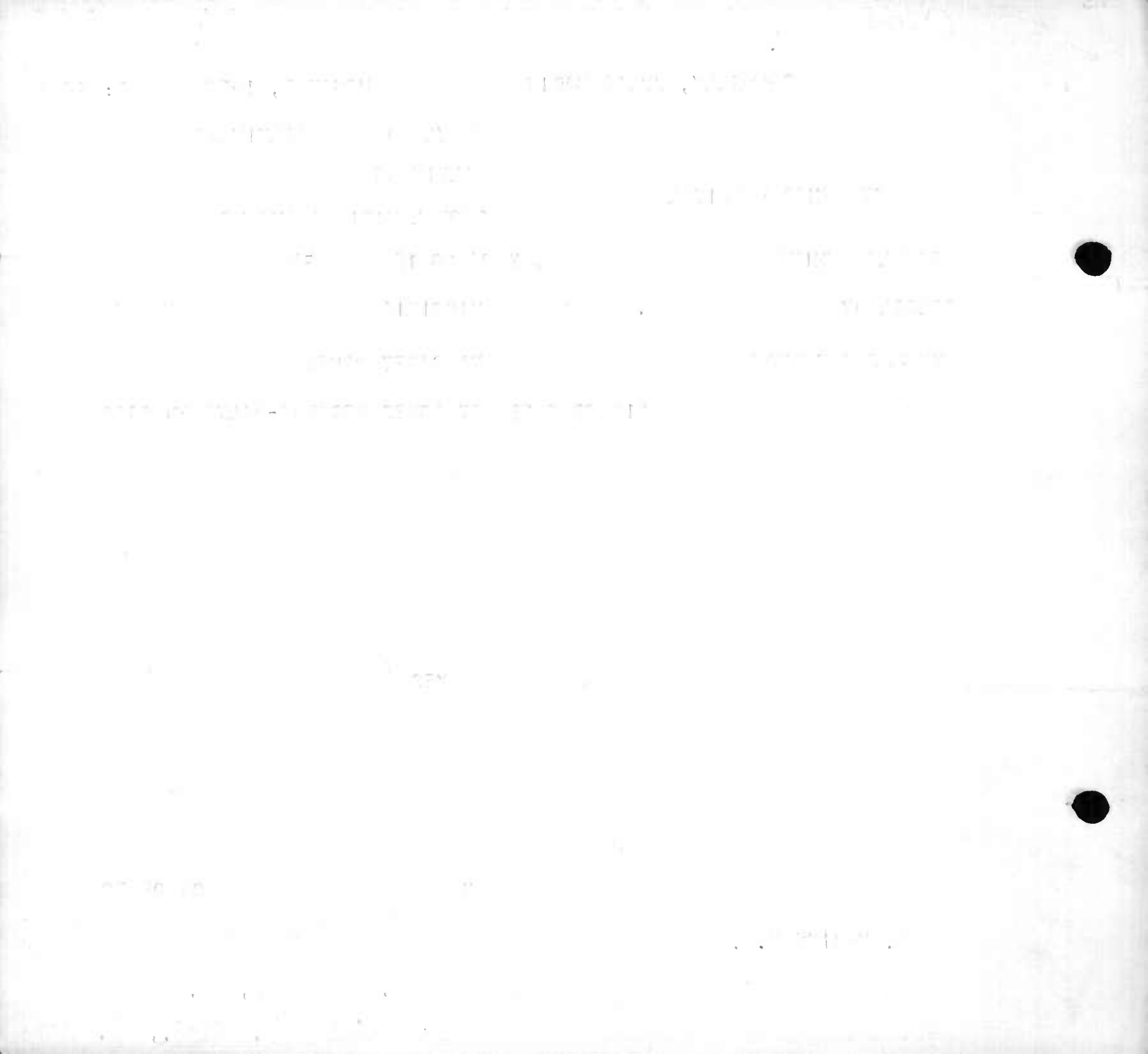
| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                                             |                                                                                                                                                 | X                                                                 |  |                                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--|-----------------------------------------------------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                                                                                                                                 | 70 7998                                                           |  |                                                                             |  |
| BIRTH NO. <u>S-345 70 7998</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             |                                                                                                                                                 | REG. NO. <u>70 7998</u>                                           |  |                                                                             |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>MARTIAN A. STALLINGS</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                                             | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> August 8, 1970<br>8:10 A. M. |                                                                   |  |                                                                             |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>31 Baltimore City Hospital</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br>August 8, 1970<br>8:10 A. M.                                                                       |                                                                   |  |                                                                             |  |
| 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             | 530                                                                                                                                             |                                                                   |  |                                                                             |  |
| 6. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 7. RACE<br><u>White</u> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | C. CITY OR TOWN<br><u>Dundalk</u>                                                                                                               |                                                                   |  |                                                                             |  |
| 9. DATE OF BIRTH<br><u>April 23, 1918</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         | 10. AGE (In years last birthday)<br><u>52</u>                                                                                                               | E. STREET AND NUMBER<br><u>242 Pinewood Road</u>                                                                                                |                                                                   |  |                                                                             |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         | 12. CITIZEN OF<br><u>U.S.A.</u>                                                                                                                             | 13. FATHER'S NAME<br><u>John Ceska</u>                                                                                                          |                                                                   |  |                                                                             |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 14B. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                                                                                                                                                 | 15. MOTHER'S MAIDEN NAME<br><u>??</u>                             |  |                                                                             |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 17. SOCIAL SECURITY NO.<br><u>213-12-6207</u>                                                                                                               | 18. INFORMANT (Husband) <u>Mr. John L. Stallings</u> ADDRESS <u>242 Pinewood Road Dundalk, Md. 21222</u>                                        |                                                                   |  |                                                                             |  |
| MEDICAL CERTIFICATION<br>19. <u>5-71-81</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>(A) IMMEDIATE CAUSE <u>Fatty metamorphosis of liver</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>II<br>20A. DATE OF OPERATION <u>2</u> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____<br>21. AUTOPSY? (Yes or No) <u>Yes</u><br>22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.<br>22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____<br>22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br>22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) _____<br>22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/><br>22F. HOW DID INJURY OCCUR?<br>23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <u>Charles S. Springate</u> M.D.<br>EXAMINER'S NAME (Type) <u>Charles S. Springate, M.D.</u><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <u>August 9, 1970</u> |                         |                                                                                                                                                             |                                                                                                                                                 |                                                                   |  |                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                                                                                                                                 | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Cremation</u>      |  | 24B. DATE<br><u>8-11-70</u>                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                                                                                                                                 | 24C. NAME of CEMETERY or CREMATORY<br><u>Greenmount Crematory</u> |  | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore, Maryland</u> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                                             |                                                                                                                                                 | 25A. DATE REC'D BY HEALTH DEPT.<br><u>AUG 11 1970</u>             |  | 25B. NAME OF REGISTRAR<br><u>Robert L. Taylor, M.D.</u>                     |  |
| 25C. FUNERAL DIRECTOR<br><u>John J. Duda</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                         | 25D. ADDRESS<br><u>7922 Wise Ave. Dundalk, Md.</u>                                                                                                          |                                                                                                                                                 |                                                                   |  |                                                                             |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             |                                                                                                                                                          | REG. NO. 70 7999                                                         |                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| C-540<br>BIRTH NO.                                                                                                                                                                                                                                                                                                                                                                                                                                     |                         | 70 7999                                                                                                                                                     |                                                                                                                                                          | CERTIFICATE OF DEATH                                                     |                                                        |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>CONNELLY, JULIA MARIE</b>                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             | 2. DATE AND HOUR OF DEATH<br><b>AUGUST 7, 1970 3: 50 P.M.</b>                                                                                            |                                                                          |                                                        |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br><b>40 ST AGNES HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> <b>5300</b> |                                                                          |                                                        |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>40 ST AGNES HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                                             | C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                         |                                                                          |                                                        |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             | E. STREET AND NUMBER<br><b>2907 LOUISIANA AVENUE</b>                                                                                                     |                                                                          |                                                        |
| 5. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>06 20 16</b>                                                                                                                      | 9. AGE (In years last birthday)<br><b>54</b>                             | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SALESLADY</b>                                                                                                                                                                                                                                                                                                                                        |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. Store</b>                                                                                                     |                                                                                                                                                          | 11. BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>             |                                                        |
| 13. FATHER'S NAME<br><b>THOMAS E GORMAN</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME<br><b>MARGARET BAHEN</b>                                                                                                        |                                                                          |                                                        |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                                             | 16. SOCIAL SECURITY NO.<br><b>219 07 5923</b>                                                                                                            |                                                                          |                                                        |
| 17. INFORMANT<br><b>ST AGNES RECORDS-BALTO MD 21229</b>                                                                                                                                                                                                                                                                                                                                                                                                |                         |                                                                                                                                                             | ADDRESS                                                                                                                                                  |                                                                          |                                                        |
| 18. <b>5719 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE <b>Bleeding Esophageal Varices</b> DUE TO, OR AS A CONSEQUENCE OF:<br><b>72 hours</b><br>(B) <b>Cirrhosis - Liver</b> DUE TO, OR AS A CONSEQUENCE OF:<br><b>years</b><br>(C) _____ |                         |                                                                                                                                                             |                                                                                                                                                          |                                                                          |                                                        |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>MEDICAL CERTIFICATION</b>                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                                                                                                                                          |                                                                          |                                                        |
| 19A. DATE OF OPERATION<br><b>21</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                                                                          | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>                                  |                                                        |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                         |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                                                    |                                                                                                                                                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                                        |
| 21D. TIME OF INJURY (APPROX.)<br>1 Month 1 Day 1 Year 1 Hour                                                                                                                                                                                                                                                                                                                                                                                           |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                                   |                                                                                                                                                          | 21F. HOW DID INJURY OCCUR?                                               |                                                        |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>4 70</b> 19 to <b>7 Aug</b> 19 <b>70</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>7 Aug</b> 19 <b>70</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.                            |                         |                                                                                                                                                             |                                                                                                                                                          |                                                                          |                                                        |
| 23A. SIGNATURE<br><b>R. UDIKE M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                                             |                                                                                                                                                          | 23B. DATE SIGNED<br><b>08 08 70</b>                                      |                                                        |
| 23C. PHYSICIAN'S NAME (Type)<br><b>R. UDIKE M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                                                                             |                                                                                                                                                          | 23D. ADDRESS<br><b>901 Pine Heights Ave, Balt, Md</b>                    |                                                        |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                              |                         | 24B. DATE<br><b>8/11/70</b>                                                                                                                                 |                                                                                                                                                          | 24C. NAME OF CEMETERY or CREMATORY<br><b>Meadowridge Memorial Pk.</b>    |                                                        |
| 24D. LOCATION<br><b>Elkridge, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 24E. NAME OF REGISTRAR<br><b>Robert E. Jaber, M.D.</b>                                                                                                      |                                                                                                                                                          |                                                                          |                                                        |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>AUG 11 1970</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Jaber, M.D.</b>                                                                                                      |                                                                                                                                                          | 25C. FUNERAL DIRECTOR<br><b>George J. Gonce Funeral Home</b>             |                                                        |
| 25D. ADDRESS<br><b>4001 Ritchie Hvy. Balto., Md. 21225</b>                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                                             |                                                                                                                                                          |                                                                          |                                                        |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT                                                                                                                                                                                                                                                                                               |  |                         |  |                                                                                                                                                             |  |                                                                  |  |                                                                                                                                 |  |                                                                                                                                      |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|
| 70 8000                                                                                                                                                                                                                                                                                                                        |  |                         |  |                                                                                                                                                             |  |                                                                  |  |                                                                                                                                 |  | 70 8000                                                                                                                              |  |
| BIRTH NO.                                                                                                                                                                                                                                                                                                                      |  |                         |  |                                                                                                                                                             |  |                                                                  |  |                                                                                                                                 |  | REG. NO.                                                                                                                             |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN A. (WAGNER) WRZESINSKI</b>                                                                                                                                                                                                                                                      |  |                         |  |                                                                                                                                                             |  |                                                                  |  |                                                                                                                                 |  | 2. DATE AND HOUR OF DEATH<br><b>August 3 1970 1:20 A.M.</b>                                                                          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>CHURCH HOME &amp; HOSPITAL</b>                                                                                                                                                                                                                                    |  |                         |  |                                                                                                                                                             |  |                                                                  |  |                                                                                                                                 |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY <b>602</b> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>33</b>                                                                                                                                                                                                                                                                              |  |                         |  |                                                                                                                                                             |  |                                                                  |  |                                                                                                                                 |  | C. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                  |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                                                                                                                                                                                                                                           |  |                         |  |                                                                                                                                                             |  |                                                                  |  |                                                                                                                                 |  | D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                           |  |
| E. STREET AND NUMBER<br><b>415 N. MILTON AVE</b>                                                                                                                                                                                                                                                                               |  |                         |  |                                                                                                                                                             |  |                                                                  |  |                                                                                                                                 |  | 21224                                                                                                                                |  |
| 5. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                          |  | 6. RACE<br><b>WHITE</b> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>6-6-98</b>                                |  | 9. AGE (In years last birthday) <b>72</b>                                                                                       |  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                                                                               |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>TOOL &amp; DIE MAKER</b>                                                                                                                                                                                                     |  |                         |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>NAT'L CANO</b>                                                                                                      |  |                                                                  |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                                                    |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                        |  |
| 13. FATHER'S NAME<br><b>ANDREW WRZESINSKI</b>                                                                                                                                                                                                                                                                                  |  |                         |  |                                                                                                                                                             |  | 14. MOTHER'S MAIDEN NAME<br><b>JOSEPHINE MAKOWSKI WRZESINSKI</b> |  |                                                                                                                                 |  |                                                                                                                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                          |  |                         |  | 16. SOCIAL SECURITY NO.<br><b>216-01-4707</b>                                                                                                               |  | 17. INFORMANT<br><b>WIFE 415 N. MILTON AVE</b>                   |  |                                                                                                                                 |  |                                                                                                                                      |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary Embolism</b>                                                                                                  |  |                         |  |                                                                                                                                                             |  |                                                                  |  |                                                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>sev. hrs.</b>                                                                     |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>hip fx Rt.</b>                                                                                                                                                                            |  |                         |  |                                                                                                                                                             |  |                                                                  |  |                                                                                                                                 |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>few days</b>                                                                               |  |
| (C) <b>fall injury</b>                                                                                                                                                                                                                                                                                                         |  |                         |  |                                                                                                                                                             |  |                                                                  |  |                                                                                                                                 |  | <b>" "</b>                                                                                                                           |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>II</b>                                                                                                                                                                                  |  |                         |  |                                                                                                                                                             |  |                                                                  |  |                                                                                                                                 |  |                                                                                                                                      |  |
| 19A. DATE OF OPERATION<br><b>21</b>                                                                                                                                                                                                                                                                                            |  |                         |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                  |  | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>                                                                                         |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b>                                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input checked="" type="checkbox"/>                                                                                                                                                                                                   |  |                         |  | 21B. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.)<br><b>HOME STREET</b>                                                    |  |                                                                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>415 N. MILTON AVE Middleton Ave</b>              |  |                                                                                                                                      |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)<br><b>JULY 29 1970 9 PM</b>                                                                                                                                                                                                                                          |  |                         |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>                                        |  |                                                                  |  | 21F. HOW DID INJURY OCCUR?<br><b>TRIPPED &amp; FELL</b>                                                                         |  |                                                                                                                                      |  |
| 22. I certify that (this hospital) attended the deceased from <b>JULY 29 1970</b> to <b>Aug 3 1970</b> that (I) (we) last saw the deceased alive on <b>Aug 3 1970</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                         |  |                                                                                                                                                             |  |                                                                  |  |                                                                                                                                 |  |                                                                                                                                      |  |
| 23A. SIGNATURE<br><b>Alfonso A. Madarang Jr. M.D.</b>                                                                                                                                                                                                                                                                          |  |                         |  |                                                                                                                                                             |  |                                                                  |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  | 23B. DATE SIGNED<br><b>8-3-70</b>                                                                                                    |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ALFONSO A. MADARANG JR. M.D.</b>                                                                                                                                                                                                                                                            |  |                         |  |                                                                                                                                                             |  |                                                                  |  | 23D. ADDRESS<br><b>CHURCH HOME &amp; HOSP</b>                                                                                   |  |                                                                                                                                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                      |  |                         |  | 24B. DATE<br><b>8/6/70</b>                                                                                                                                  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Holy Rosary Cem.</b>    |  |                                                                                                                                 |  | 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE MD</b>                                                                 |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>AUG 11 1970</b>                                                                                                                                                                                                                                                                          |  |                         |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Tabor, M.D.</b>                                                                                                      |  |                                                                  |  | 25C. FUNERAL DIRECTOR<br><b>RAYMOND L. KACZOROWSKI</b>                                                                          |  |                                                                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                |  |                         |  |                                                                                                                                                             |  |                                                                  |  | ADDRESS<br><b>2525 FLEET ST.</b>                                                                                                |  |                                                                                                                                      |  |

